Building An Effective Infrastructure For Value-Based Contracting

Meeting Dates: May 5th, 2022 1:00PM

May 10th, 2022 10:00AM

Agenda

I. The Value-Based Business Model
II. The Role Of Data In Driving Value
III. Competencies For Success With Value-Based Contracting

Learning Objectives

- Understand approaches that organizations are taking to implement value-based care.
- Identify the benefits and risks of common alternative payment methods.
- Understand key competency domains that are important for success in a value-based reimbursement market.

I. The Value-Based Business Model

The Shifting Reimbursement Market

Reimbursement Model	Focus	Methods
Fee-For-Service	Access and cost management	Managing volume, negotiating rate, managing contractual processes
Value-Based Reimbursement	Quality outcomes for the best price	Aligning payment methods to support consumer satisfaction and quality outcomes

Goals of Value-Based Contracting

1. Increase Transparency Of Performance

- Increase "pressure" for improvement
- Facilitate consumer-directed care

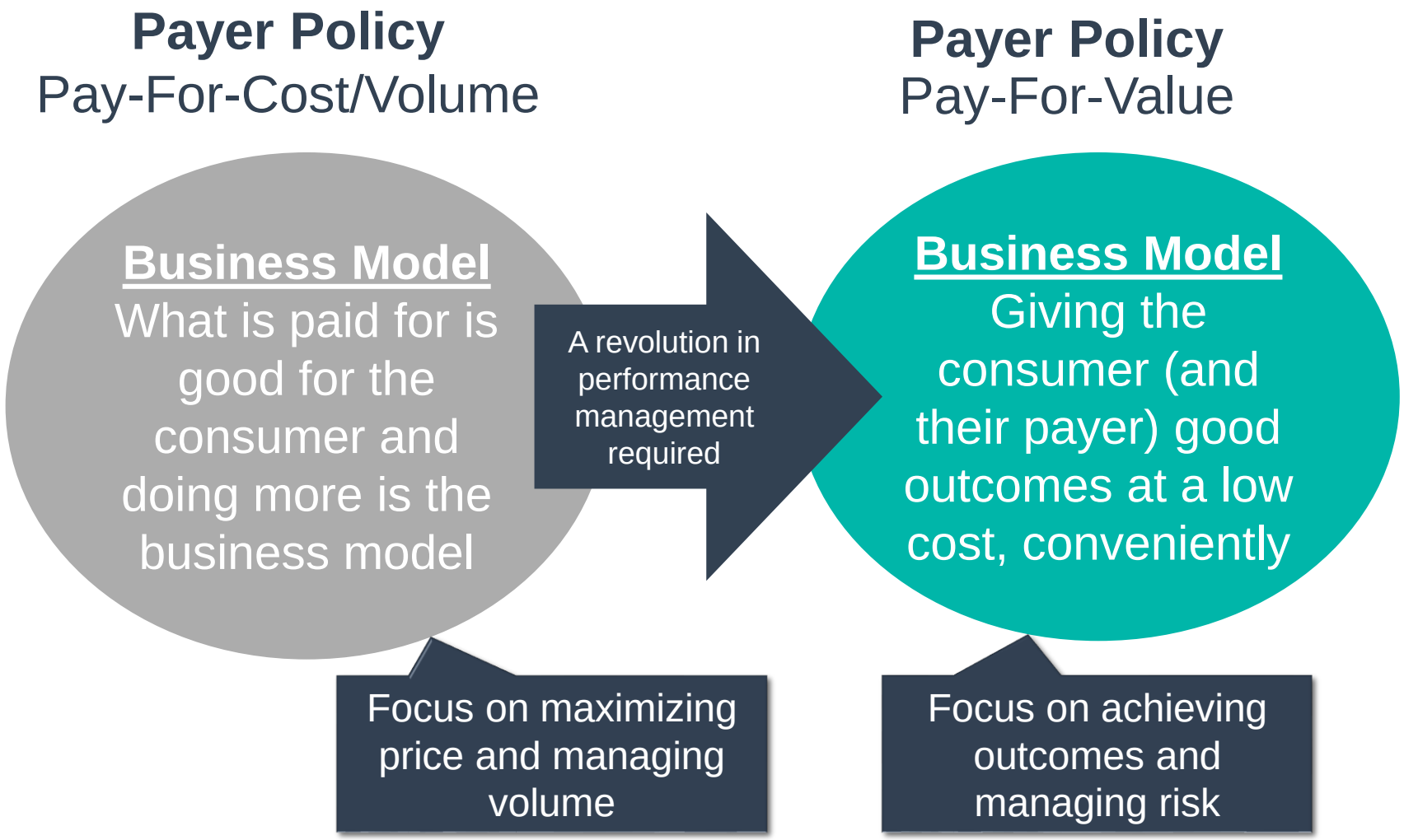
2. Link Professional, Service Provider Organization, & Care Manager Reimbursement To Desired Performance

- Improved access to care
- Increase care integration and coordination
- Person-centered planning and recovery focus

3. Control Costs Of Care

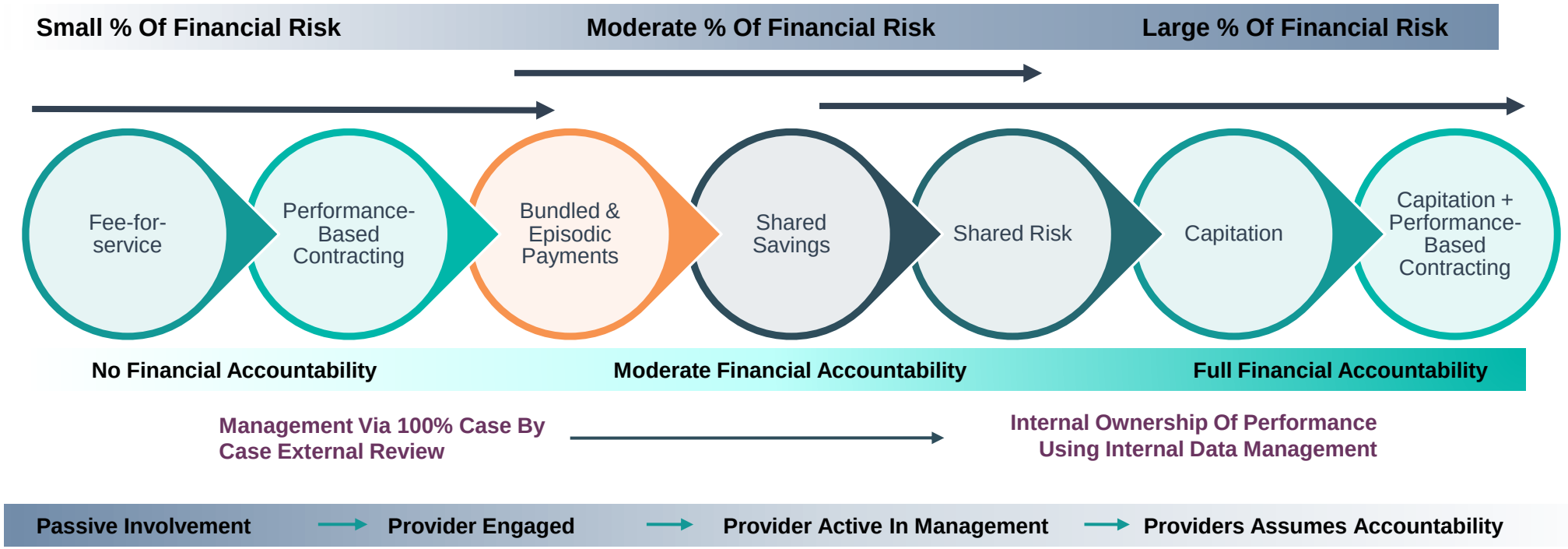
- Financial incentives to help consumers become and remain healthy for longer periods of time
- Increase lower-cost interventions for "not yet seriously ill" population
- Reduce unnecessary use of high-cost services

Business Model Transition For Provider Organizations



Health Plan Reimbursement Moving From Volume To Value: Supporting 'Integrated Care Coordination'

Compensation Continuum By Level Of Financial Risk



HCP-LAN Model Of Value-Based Reimbursement

Category 1

Fee For Service – No Link To Quality & Value

Category 2

Fee For Service – Link To Quality & Value

A

Foundational Payments For Infrastructure & Operations
(e.g., care coordination fees and payments for HIT investments)

B

Pay For Reporting
(e.g., bonuses for reporting data or penalties for not reporting data)

C

Pay-For-Performance
(e.g., bonuses for quality performance)

Category 3

APMs Built On Fee-For-Service Architecture

A

APMs With Shared Savings
(e.g., shared savings with upside risk only)

B

APMs With Shared Savings & Downside Risk
(e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)

3N **Risk-Based Payments NOT Linked To Quality**

Category 4

Population-Based Payment

A

Condition-Specific Population-Based Payment
(e.g., per member per month payments, payments for specialty services, such as oncology or mental health)

B

Comprehensive Population-Based Payment
(e.g., global budgets or full/percent of premium payments)

C

Integrated Finance & Delivery System
(e.g., global budgets or premium/full percent of premium payments in integrated systems)

4N **Capitated Payments NOT Linked To Quality**

Pay-For-Performance

Definition: Providers are financially rewarded for meeting pre-established targets for delivery of health care services

Pros

- Incentivizes behavior change
- Lead to improvement of quality measures
- Encourage more efficient coordination

Cons

- Provider only focused on care that affects measures, and ignore other factors - “manage to metric” or “cherry pick” member
- Incentive may not be large enough to promote behavior change
- Provider could see overall reduction in revenue if unable to fill vacancy
- Difficult to evaluate causality v. random fluctuation

Pay-For-Performance Example

- “ABC” Health Plan pays an escalator of up to 6% for rev code 124 (acute inpatient level of care) based on achievement of HEDIS 7-day ambulatory follow up
- “ABC” Plan pays a one-time bonus of $50,000 for achievement of key performance measures included assuring consumer compliance with annual dentist visit

Case Rate Or Bundled Rate

Definition: A flat payment for a group of procedures and/or services

Pros

- May decrease need for authorization and concurrent review
- Controls cost per episode
- Incentivizes fewer re-admissions
- Can bundle multiple services and promote innovation

Cons

- Incentivizes shifting treatment to other settings or codes
- Increase oversight to manage quality
- Increases risk to providers
- Potential for double payment if member switches provider
- Encourages discharge once member passes breakeven point
- Incentivizes admissions
- Need to make many assumptions, e.g.. service mix, license mix, etc
- Requires system to support

Case Rate Or Bundle Rate Example

- "ABC" Health Plan pays a monthly rate of $1,200 for Medication Assisted Treatment (MAT) to include medication management, counseling services, and lab services associated with treatment, excluding medication costs
- "XYZ" Health Plan pays a case rate of $7,000 for acute inpatient episode to include all services (e.g., physician fees, labs, etc.) for a single treatment episode. A readmission warranty includes a 10% withhold for any case that is readmitted within 90 days of treatment
- "EFG" Health Plan pays a tiered case rate of $800 for day 1 of treatment, $600 for days 3-5, and $200 for Days 6 and 7 with no payment after day 7 for acute inpatient treatment

Shared Savings & Shared Risk

Definition: Provider and payer share in the healthcare savings pool generated by performance improvement (e.g., reduced behavioral costs or total cost of care)

Pros

- Offer a reward split among those contributing to the success (e.g., payer supports analytics and member assignment and provider implements interventions to reduce costs)
- Shared risk is a variation in which the provider is at risk for the service costs
- Good step toward capitation if successful

Cons

- "Shared" is not always a 50/50 share
- Achievement may result in little room for ongoing improvement—need to develop go-forward model of sustainability

Shared Savings & Shared Risk Example

- A Core Service Agency (CSA) offers a full continuum of care and has been assigned 500 seriously and emotionally disturbed (SED) children to manage with a goal of improving community tenure and reducing out-of-state foster care placement. Achievement of pre-defined target measures (using baseline year of data) will result in the Plan and the CSA splitting the savings (generated from reduced higher level of care costs) 50/50
  - Variation – CSA is at risk for the membership and splits any achievement with the Plan, but must pay all services and provide transparency into service utilization and costs

Capitation

Definition: A set payment for each enrolled person assigned to that physician or group of physicians, whether or not that person seeks care, per period of time

Pros

- Rewards groups, and in turn those groups' individual physicians, who deliver cost-efficient care
- Costs stable and predictable
- No billing

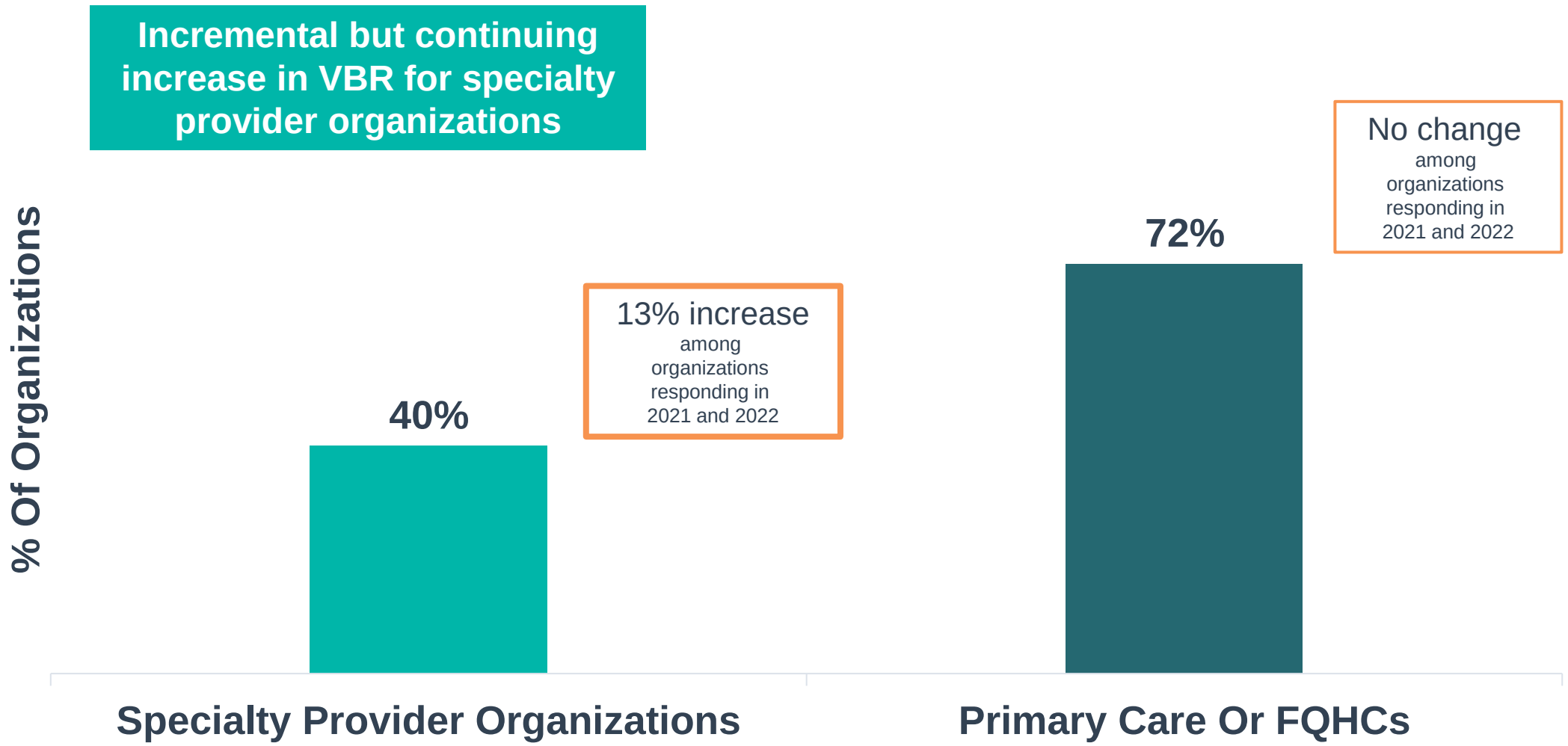
Cons

- Takes away from our value proposition, we lose control
- Selection incentives; promotes under-treatment
- Dependent on marketplace factors and a group's negotiating prowess
- Difficult to reduce capitation payments
- Increase need for oversight
- Must ensure provider stays solvent
- Regulatory hurdles
- Requires system to support

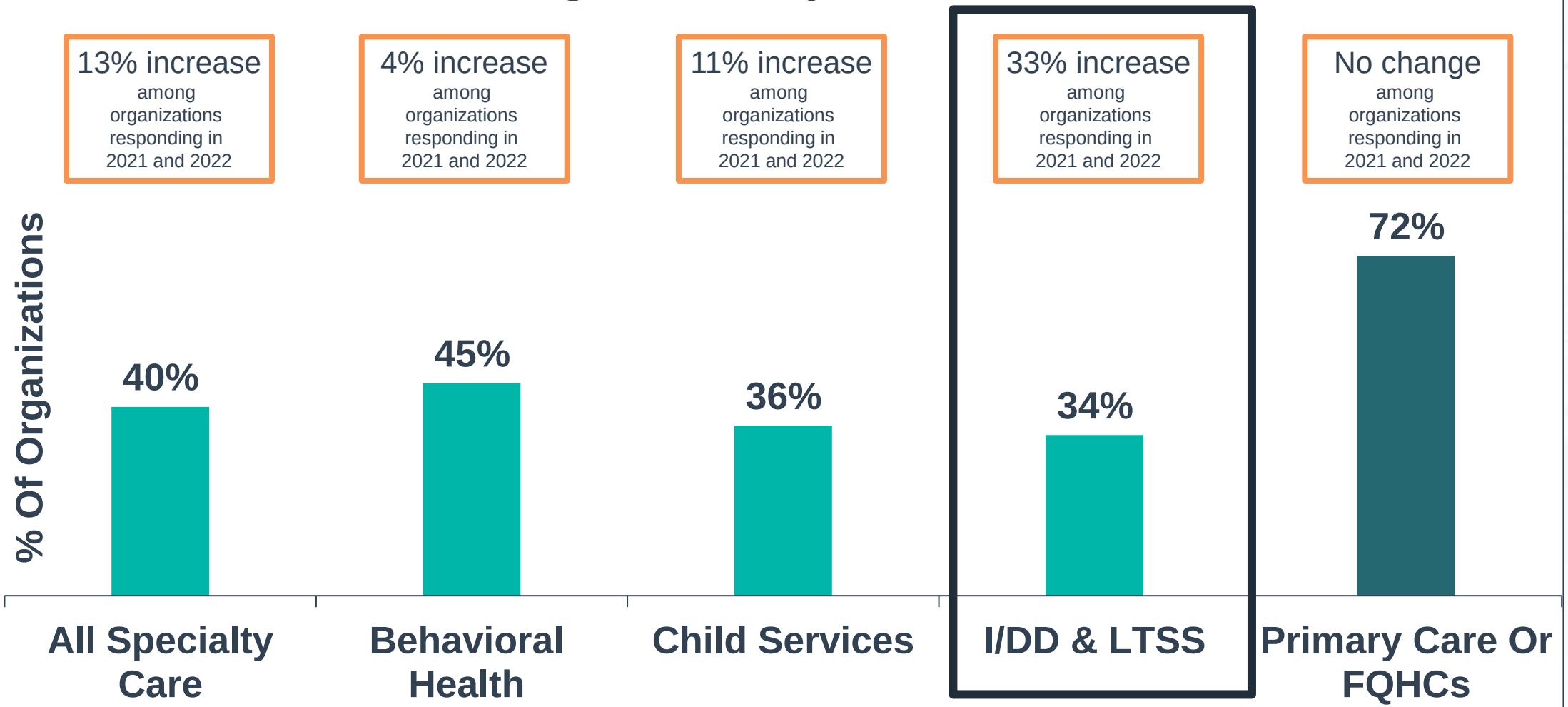
Capitation Example

- An outpatient provider is paid a per member per month (PMPM) to support the care coordination of an assigned cohort of 500 individuals that meet the state definition of severe and persistent mental illness (SPMI). The provider can earn a bonus on top of the PMPM if key performance measures are achieved.

Specialty & Primary Care Provider Organizations Participating In VBR Arrangements, %, 2022



Specialty & Primary Care Provider Organizations Participating In VBR Arrangements, By Market, %, 2022

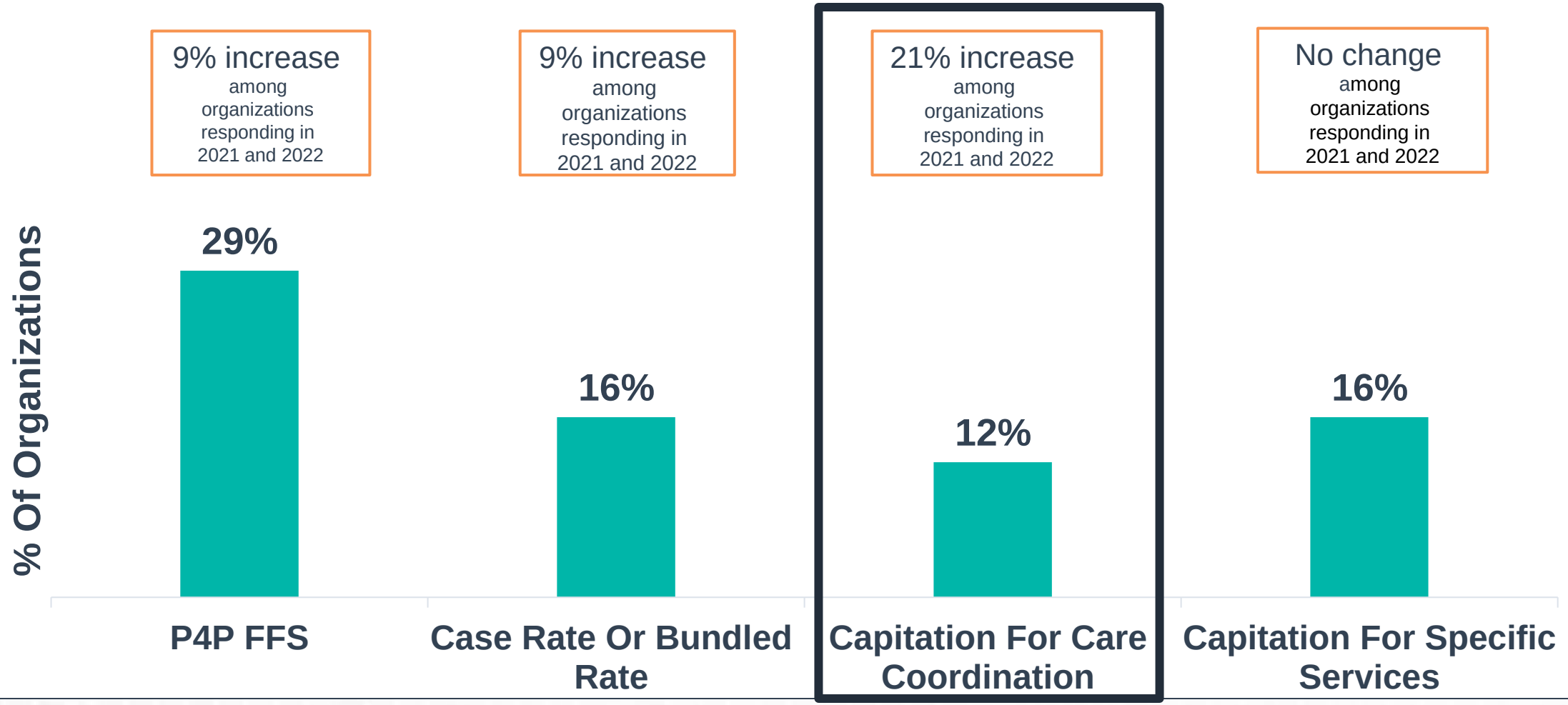


Health plan includes commercial health plans, Medicaid managed care plans, and Medicare Advantage plans

Specialty Provider Organizations Only Participating In VBR Arrangements, By Revenue, %, 2022

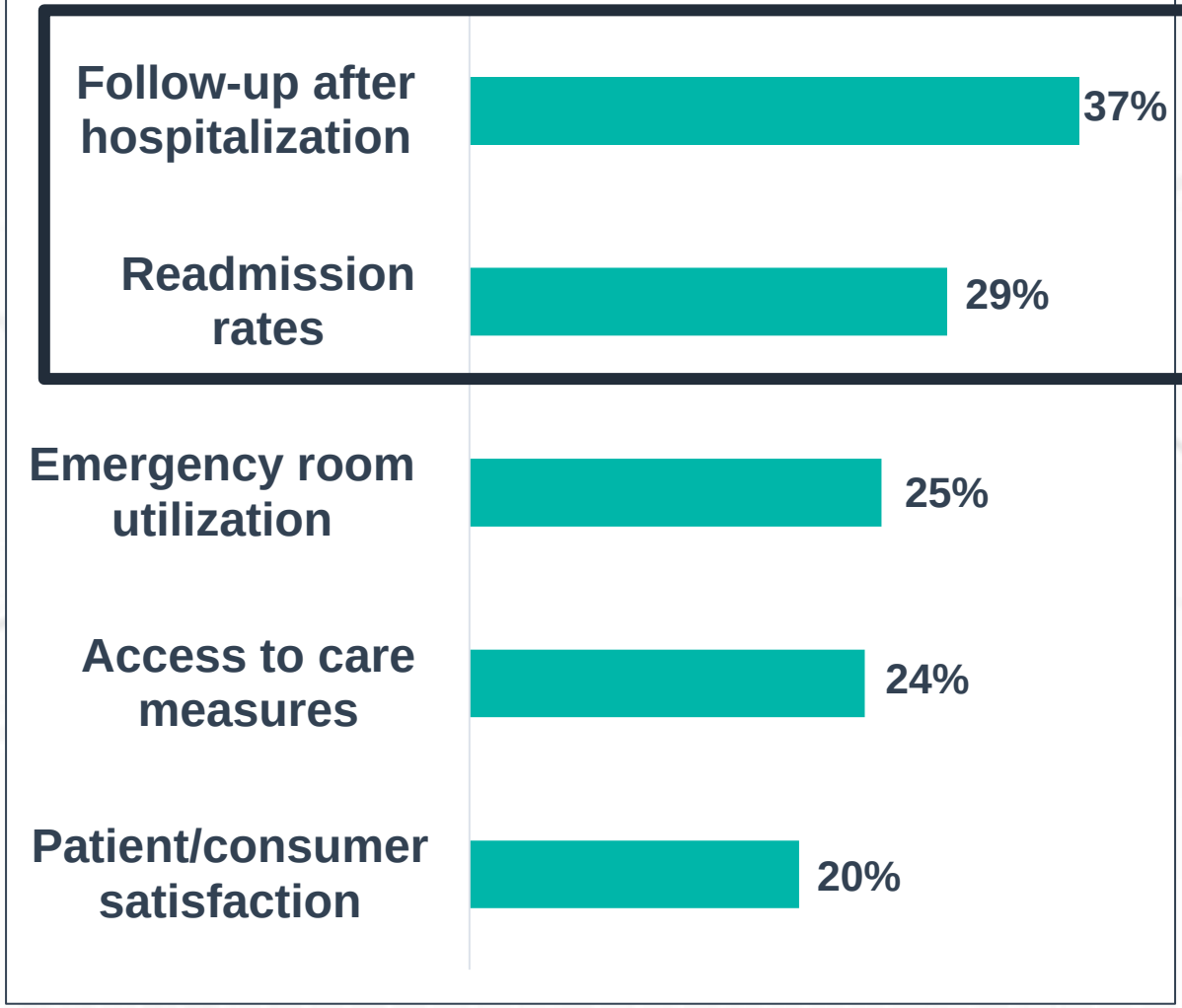
Health plan includes commercial health plans, Medicaid managed care plans, and Medicare Advantage plans

Specialty Provider Organizations Only Participating In VBR Arrangements, By VBR Type, %, 2022

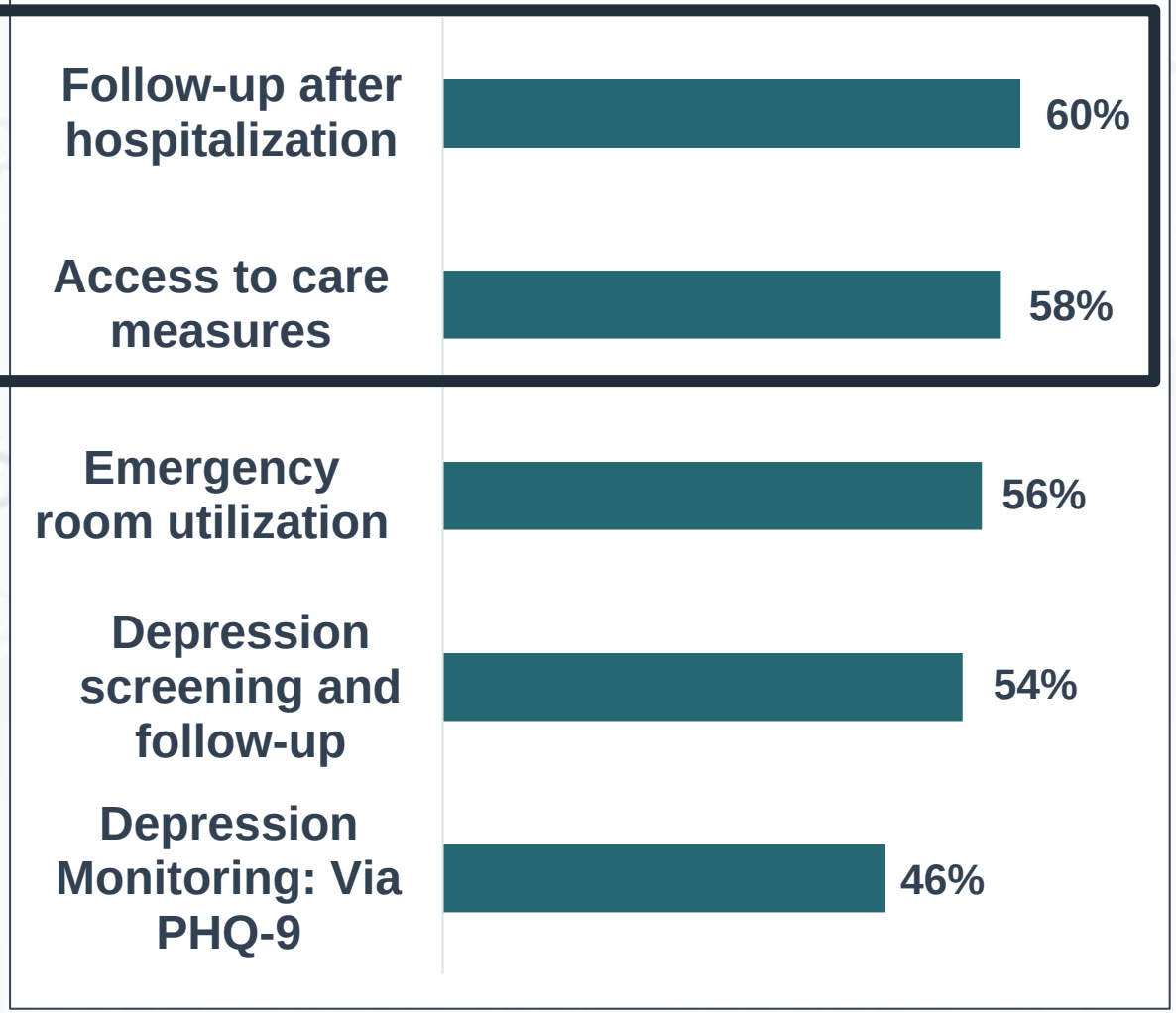


*Note provider organizations could select that they were participating in more than one type of VBR arrangement

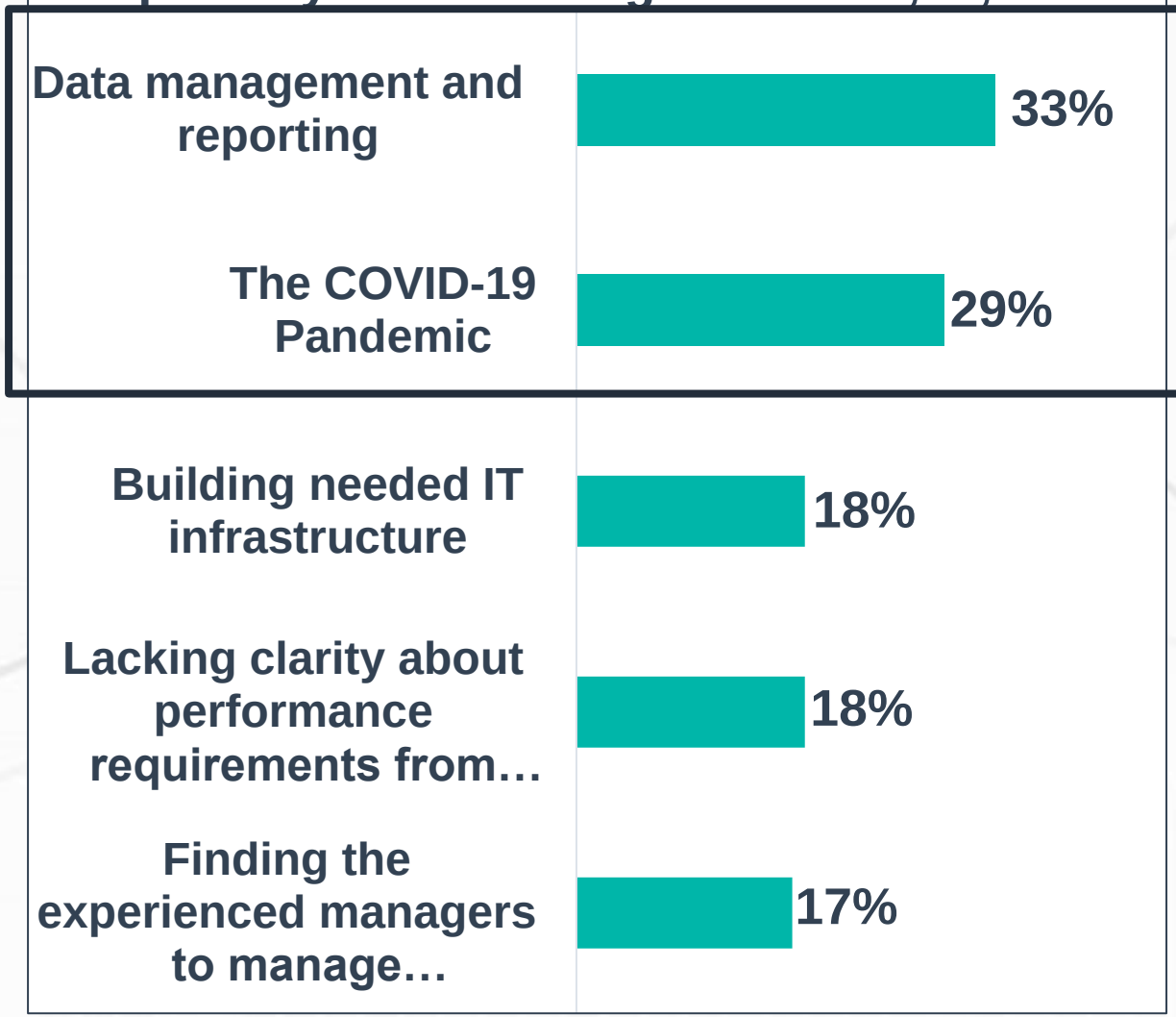
Top Five Performance Measures In Value-Based Contracts, Specialty Provider Organizations, %, 2022



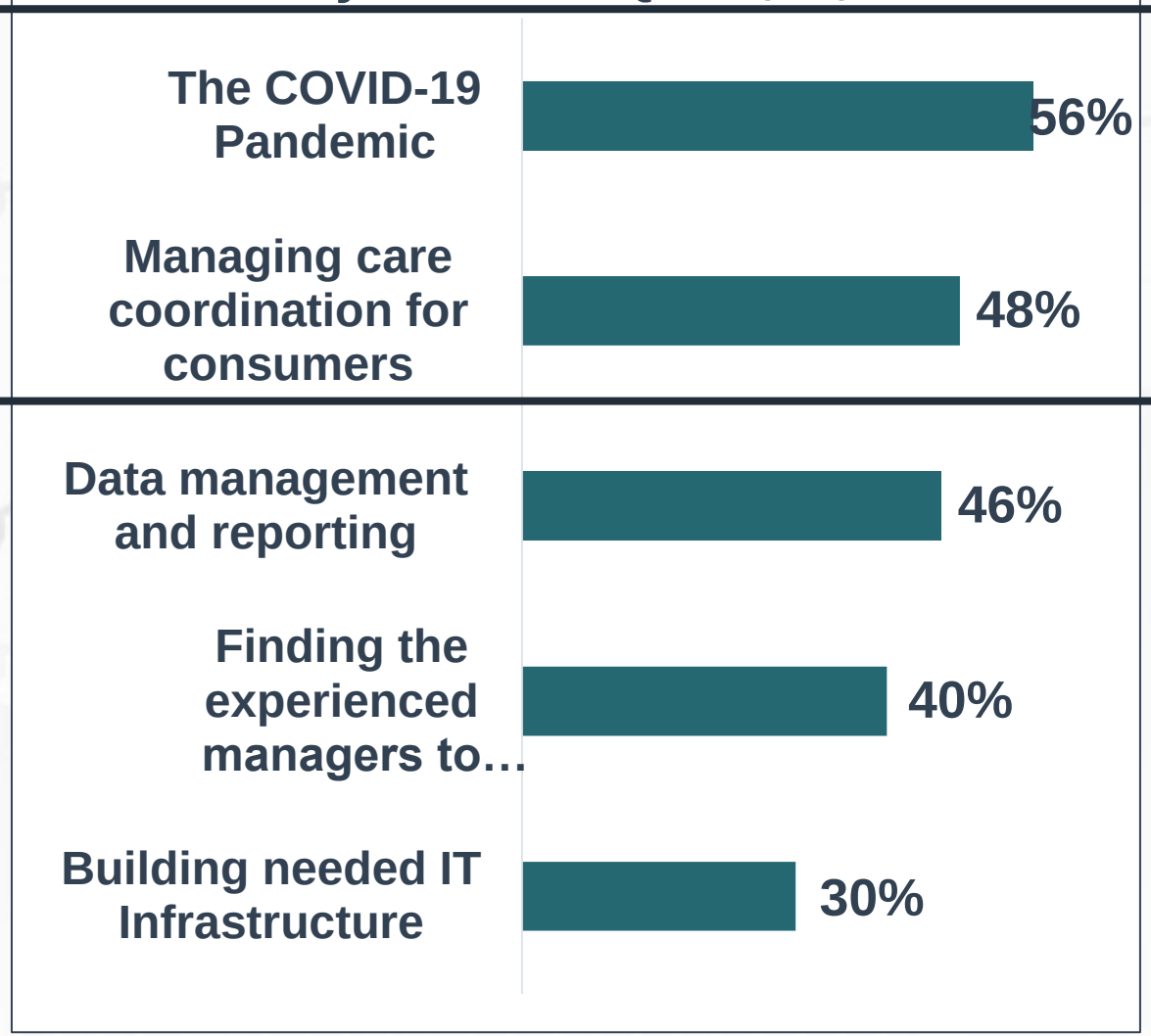
Top Five Performance Measures In Value-Based Contracts, Primary Care Or FQHCs, %, 2022



Top Five Challenges To Managing Value, Specialty Provider Organizations, %, 2022



Top Five Challenges To Managing Value, Primary Care Or FQHCs, %, 2022



Most Used Behavioral Health Performance Measures

- Follow-up after hospitalization for mental illness
- Emergency room utilization
- Readmission rates
- Patient or consumer satisfaction
- Use of evidence-based care protocols
- Access to care measures
- Diabetes screening for those using antipsychotics
- Antidepressant medication management
- Community tenure
- Depression monitoring via PHQ-9
- Patient reported outcomes
- Involvement of family/significant other
- Engagement of alcohol and other drugs treatment
- Diabetes care – blood sugar controlled
- Adherence to antipsychotic medication
- Risk adjusted ALOS

Services Focused On Creating Value Through Effective Outcomes

1. Behavioral health service system sub-capitation
2. Specialty care coordination for consumers with behavioral disorders
3. Specialty “Center of Excellence” programs for acute conditions
4. Behavioral health consultation program for inpatient programs – live or via telehealth
5. Hospital diversion programs
6. Specialty behavioral health ER/crisis stabilization
7. Management of specific acute episodes or chronic conditions via case rate or episodic/bundled payment
8. Management of short-term inpatient psychiatric and addiction treatment programs
9. Hospital readmission prevention programs
10. Community-based/mobile crisis response
11. Home-based service delivery
12. Specialty primary care

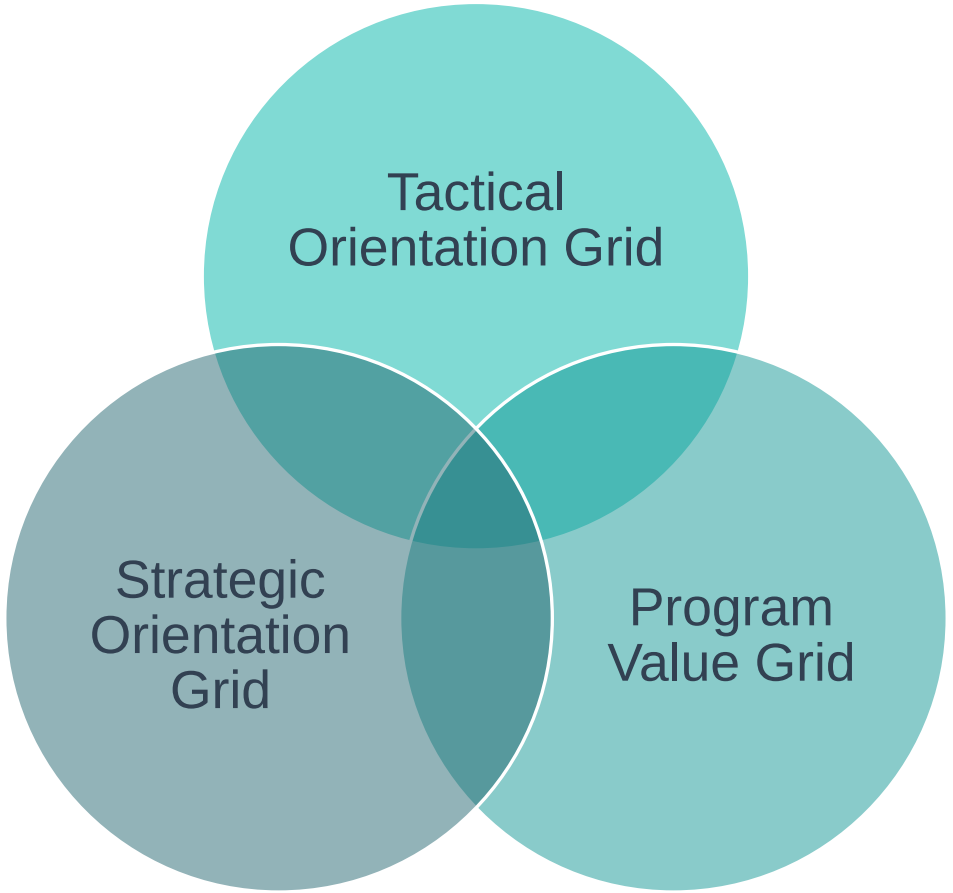
Strategic Implications Of Value-Based Contracting

1. Provider organizations will be expected to be partners in these activities.
2. There are likely to be significant modifications in business approach for providers to succeed in value-based contracting.
3. The continuum of value-based purchasing from limited risk to enhanced risk must be addressed.
4. Developing relationships with other providers so that a continuum of services will likely create advantages to savvy providers.

II. The Role Of Data In Driving Value

The Role Of Data & Technology In Value-Based Reimbursement

Achieving Data-Driven Decision Making

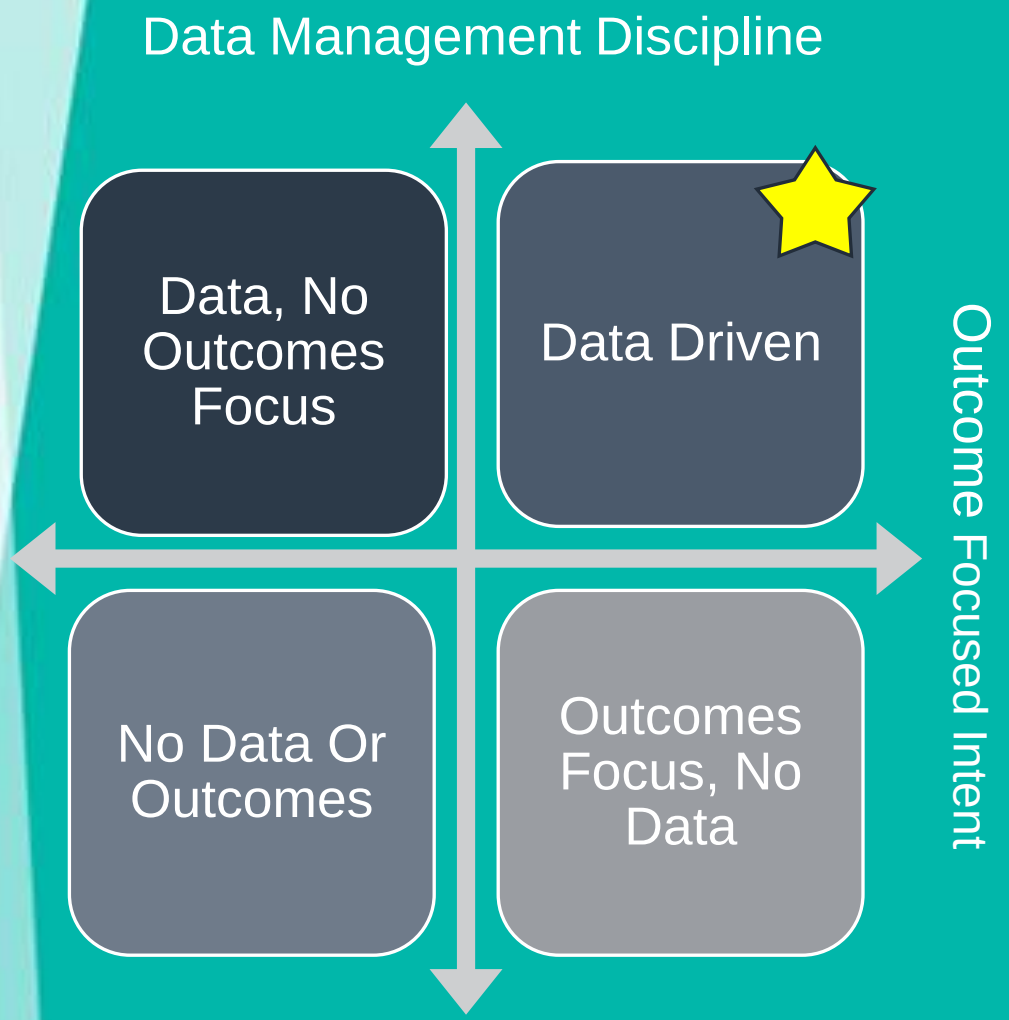


Data-driven organizations tactically use data to measure outcomes, strategically adapt services to improve outcomes, and ensure alignment with service consistent service goals

Tactical Data Focus

Tactical Orientation Grid

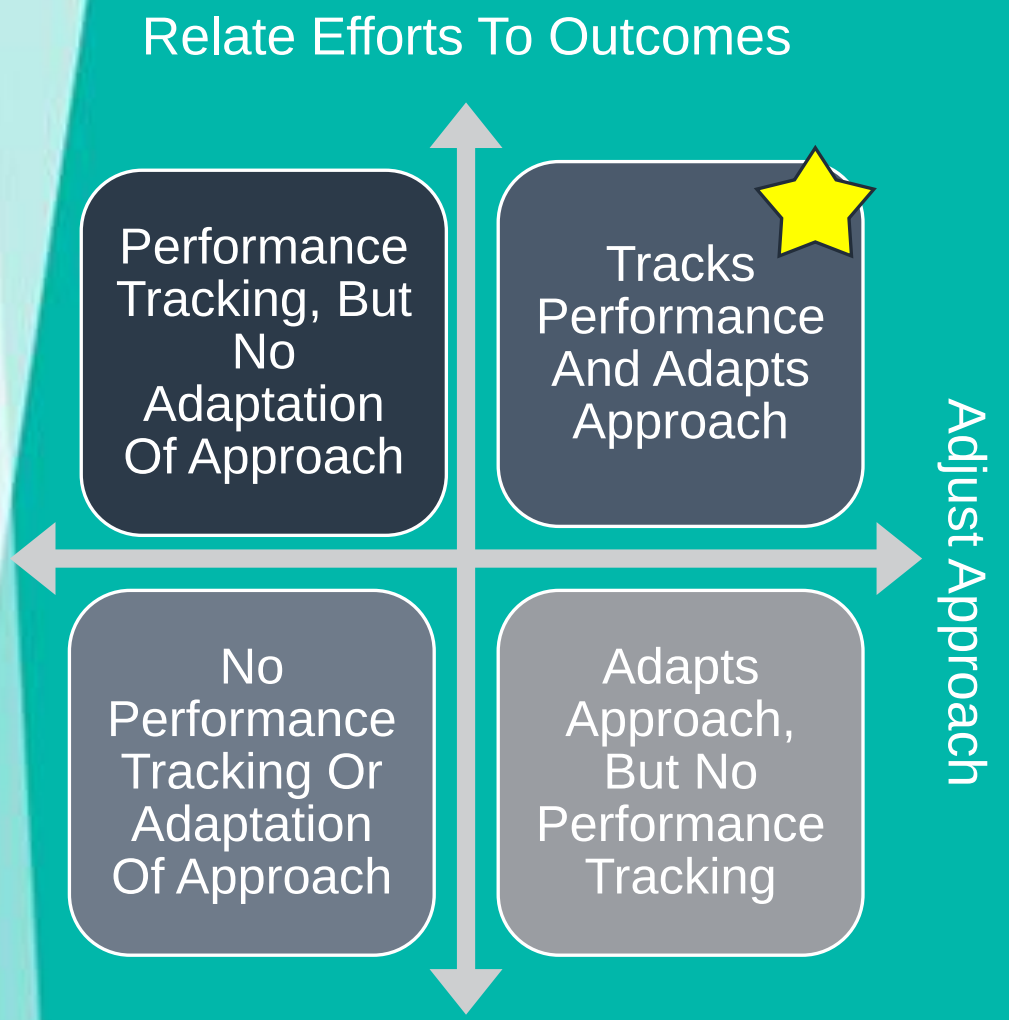
- Assesses organizations on their tactical infrastructure to capture data, and cultural focus to use data to drive better outcomes
- Data-driven organizations must have **data** and an **outcomes focused intent to use that data**



Strategic Data Focus

Strategic Data Orientation Performance Domain

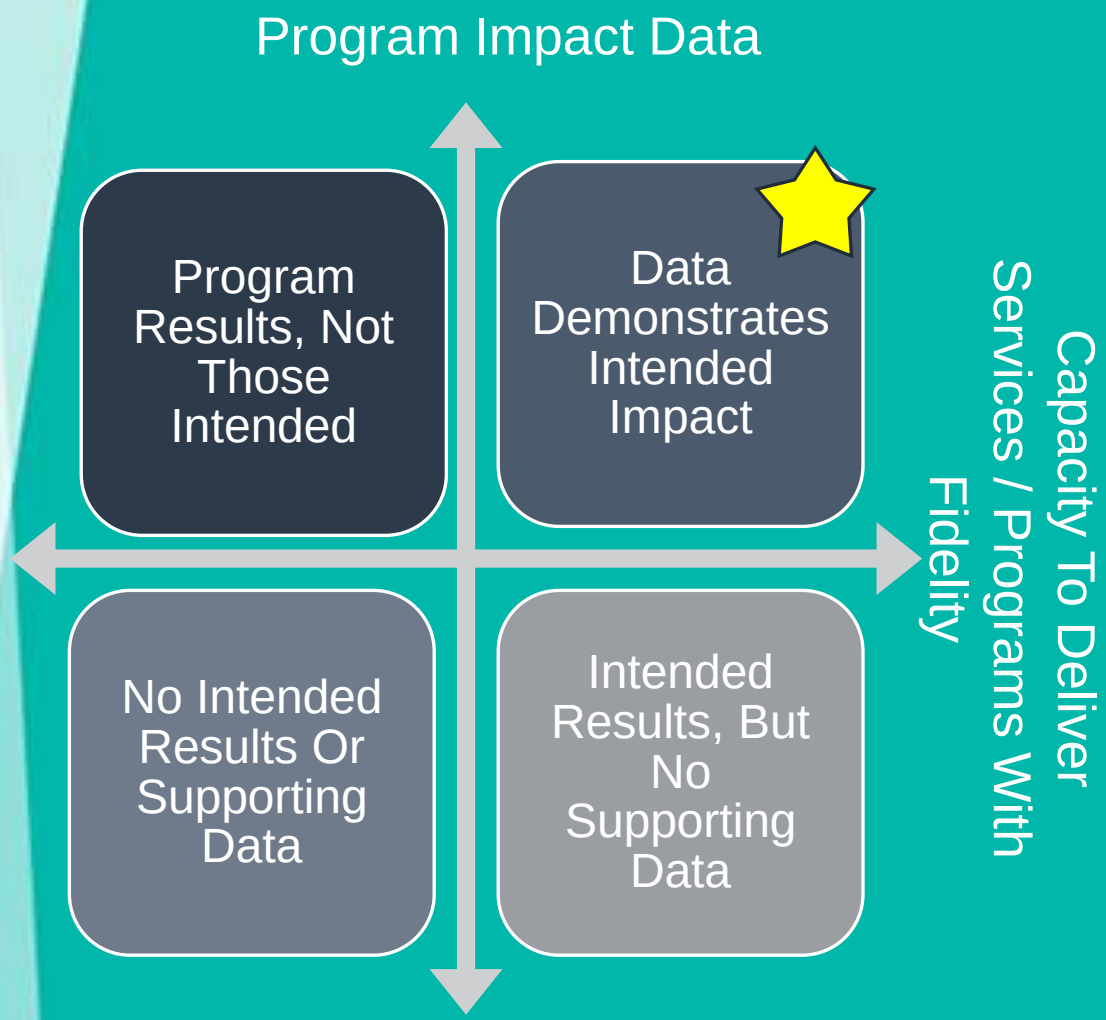
- Assesses organizations on their ability to adapt performance to improve outcomes
- Data-driven organizations must **track and analyze service outcomes**, and **adapt performance** to create social value



Program Impact Data Focus

Program Value Performance Domain

- Assesses organizations on their ability to deliver intended outcomes
- Focus is on **program impact data**, and **capacity to deliver contracted/intended outcomes**



The *OPEN MINDS* Key Performance Domains For Health & Human Service Provider Organizations

"High Performing" On Payer Contracts

- National health home measures
- NCQA HEDIS measures
- CMS STARS measures
- Most common health plan contract measures
- Specific health plan contract measures
- Specific funder performance measures

The Speed & Cost Factors

- Search engine ranking and optimization scores
- Online reputation
- Inquiries
- Inquiry response time
- Inquiry conversion rates
- Time to appointment
- Service rates
- Rate-value linkage

The Consumer Experience

- Net promoter score
- Customer satisfaction
- Customer experience monitoring ("mystery shopper") results

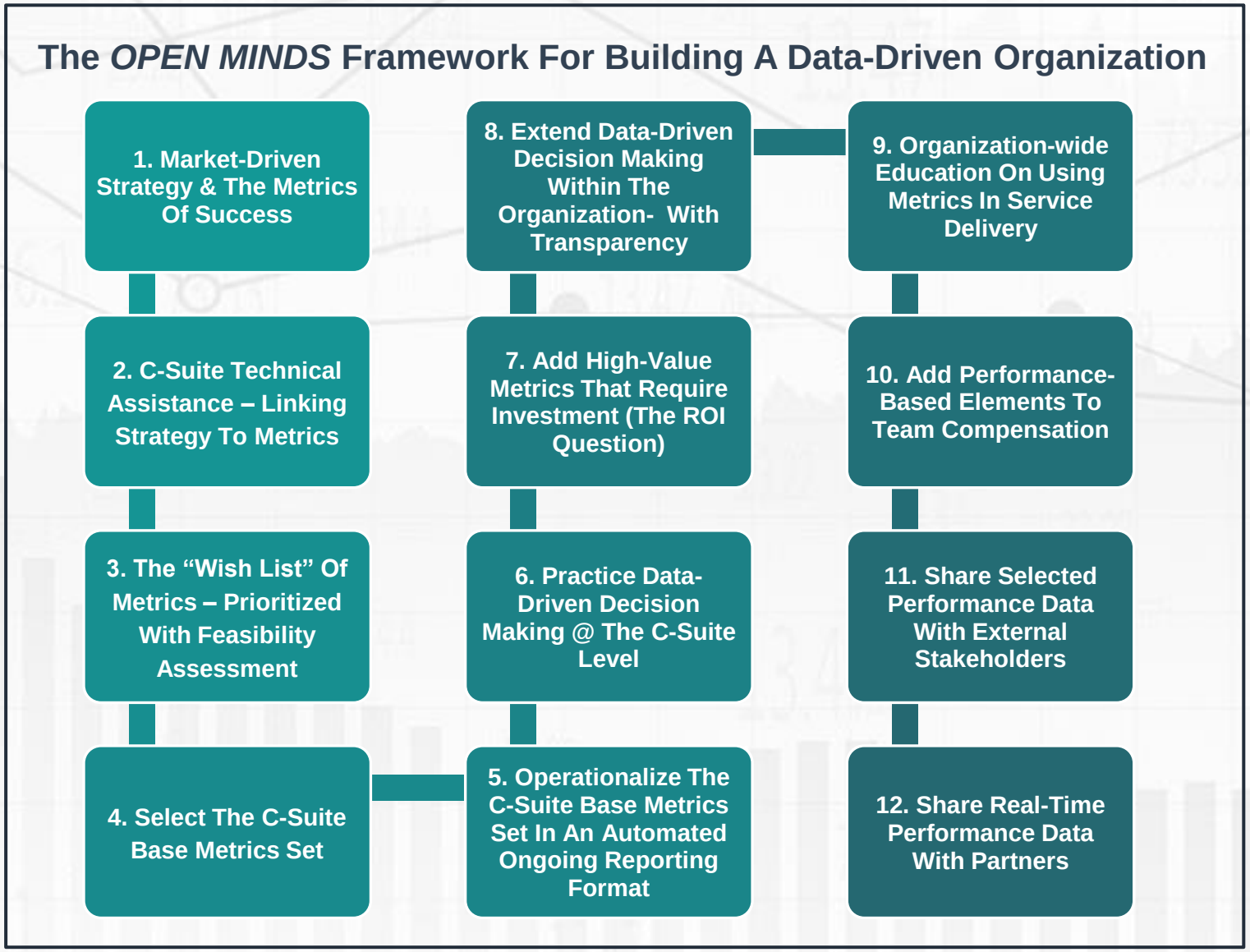
Clinically Cutting Edge

- Consistency in "treatment model" – lack of unexplained variability
- Current in clinical and service practices
- Short time to evaluation and adoption of new treatment technology

Financial Sustainability

- Revenue – by service line
- Liquidity – current ratio, days cash outstanding, cash flow from operations, days of accounts receivable
- Profitability – revenue growth and net operating profit margin, by service line
- Leverage – debt to equity ratio

Data-Driven Decisionmaking – Experience Is Not Enough Right Now



- Advantage goes to the organization with the right data – fast….
- Even in a crisis, it's important to focus on building a data-driven team
- Data reinforces objectives – and promotes order over control
- Data supports communication as creates a common vocabulary and understanding

III. Competencies For Success With Value-Based Contracting

Six Domains In *OPEN MINDS* Model For Assessing Value-Based Reimbursement Management Readiness

I. Provider Network Management

II. Clinical Management & Clinical Performance Optimization

III. Consumer Access, Service, & Engagement

IV. Financial Management

V. Technology & Reporting Infrastructure

VI. Leadership & Governance

I. Provider Network Management

Competencies:

- **Ability to negotiate contracts, manage credentials of clinicians, and meet the requirements of payer organizations.**
- **Ability to identify care management needs, obtain payer authorizations and refer to appropriate services.**

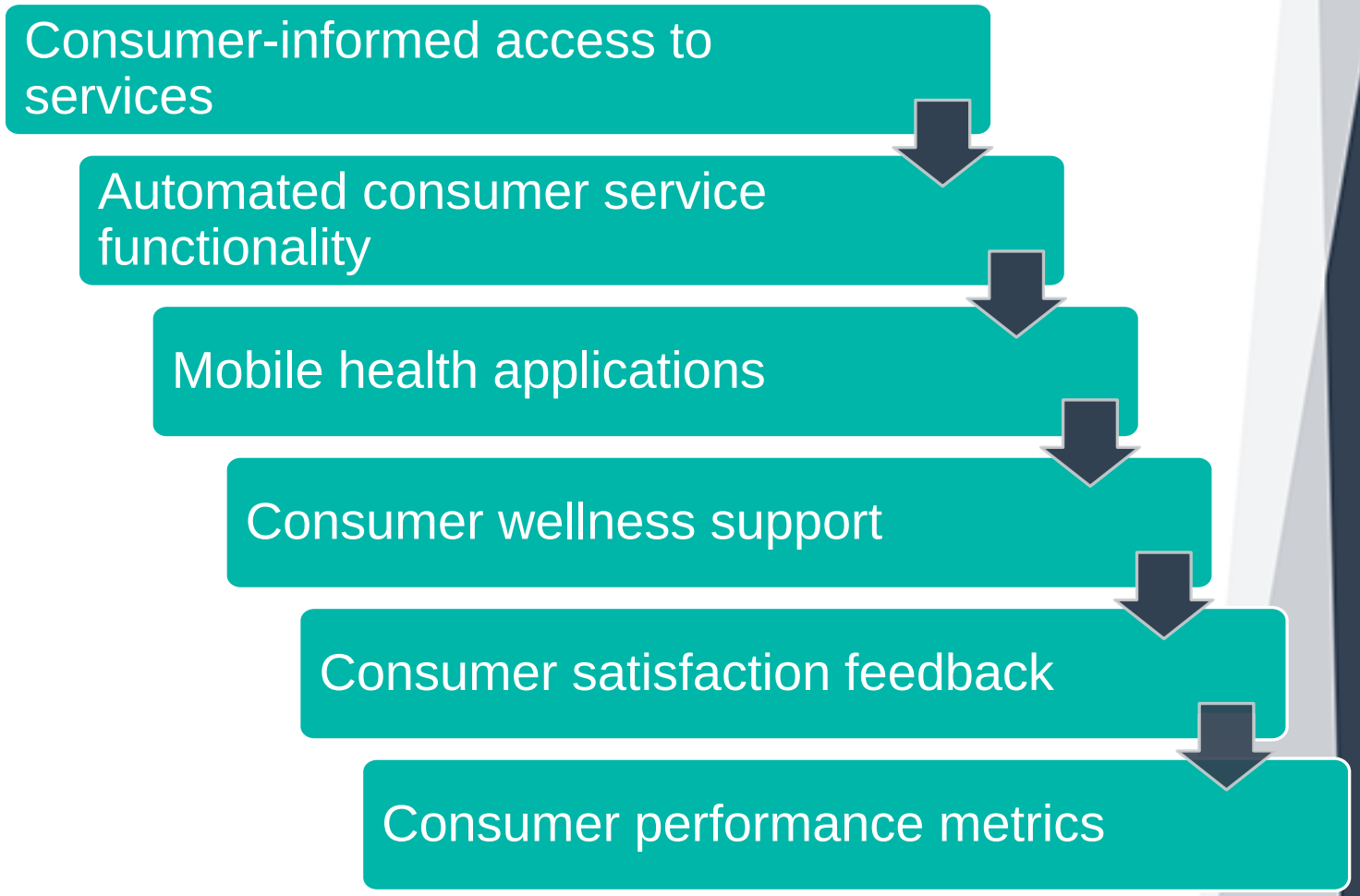
II. Clinical Management & Performance Optimization

- Clinical Decision Support Tools
- Care Standardization Protocols
- Clinical Performance Tracking & Outcomes Optimization

Competencies:

- **Ability to use data to determine the most effective evidenced-based practices.**
- **Ability to track outcomes, assess how to optimize services, and implement performance improvements.**

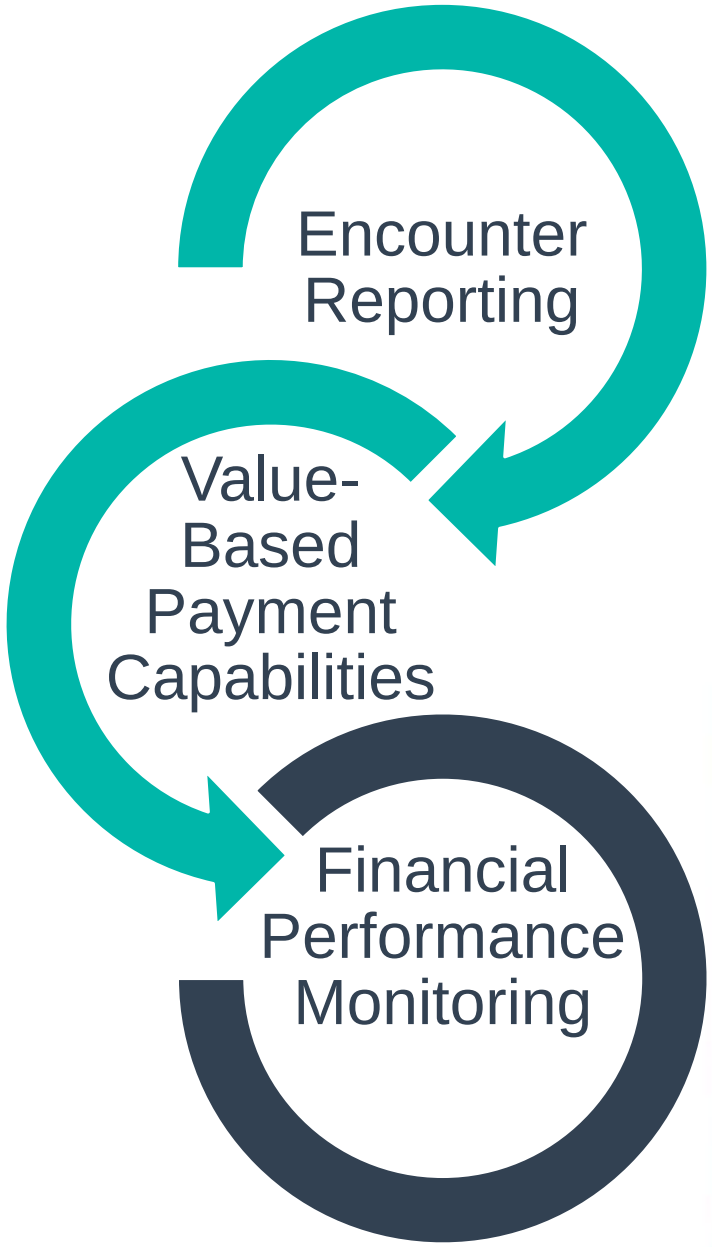
III. Consumer Access, Customer Service, & Consumer Engagement



Competencies:

- **Technology to improve consumer access to self-service tools for both clinical and administrative services.**
- **Technology and support to maximize consumer engagement and wellness.**
- **Ability to obtain frequent consumer feedback through easy, non-obtrusive methods and analyze outcomes, identify options to improve services based on performance metrics.**

IV. Financial Management



Competencies:

- **Ability to align operational and financial processes to capture, analyze, and report data and assure adequate cash flow.**
- **Systematic approach to calculating and managing unit costs.**
- **Ability to project revenue and expenses based on contractual outcomes.**

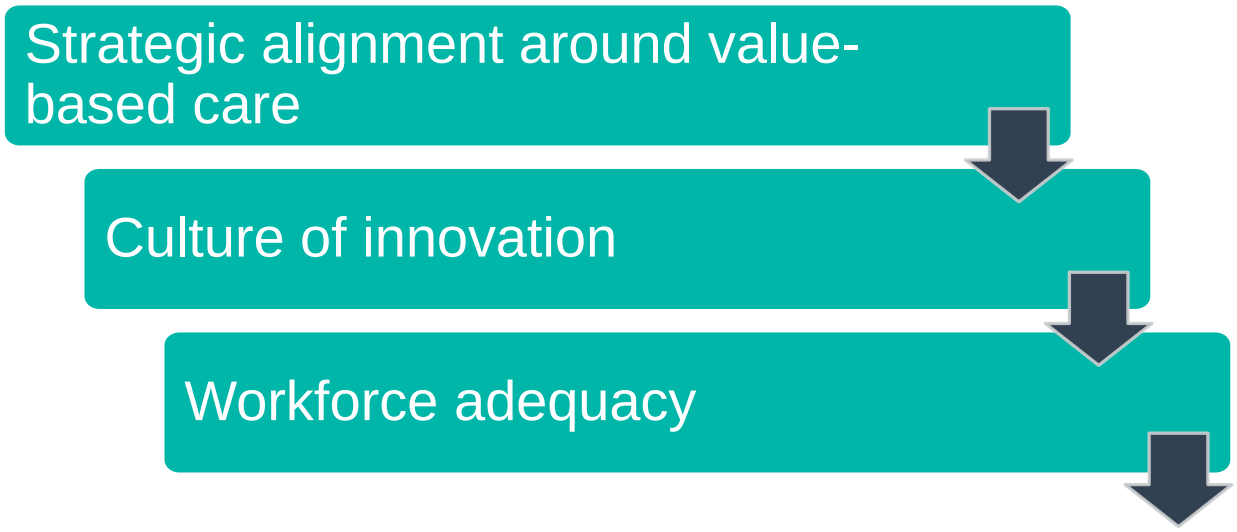
V. Technology & Reporting Infrastructure

- Capacity To Collect Data
- Capacity To Analyze Data For Population Health Management
- Ability To Manage Value-Based Contracts
- Ability To Exchange Healthcare Information
- Care Management Functionality
- Consumer Portal Functionality

Competencies:

- **Technology infrastructure to collect and analyze data strategic in identifying health needs of the population of consumers served.**
- **Ability to track performance metrics, submit invoices, and maximize performance of value-based contracts.**
- **Ability to provide service data, resources and interaction options with consumers through the EHR.**

VI. Leadership & Governance



Competencies:

- **Strategic alignment of leadership around delivering and contracting for value-based care and using date to manage financial risk.**
- **The right staff level of staffing, openness to change, and expertise to develop new services.**

Questions & Discussion

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