CENTER *for* INTEGRATIVE HEALTH

insight to innovation

Convene.
Strategize.
Activate.

Value Based Reimbursement that Supports Whole Person Care

Carole Matyas

WellCare Heath Plan, Inc.

WellCare's Presence

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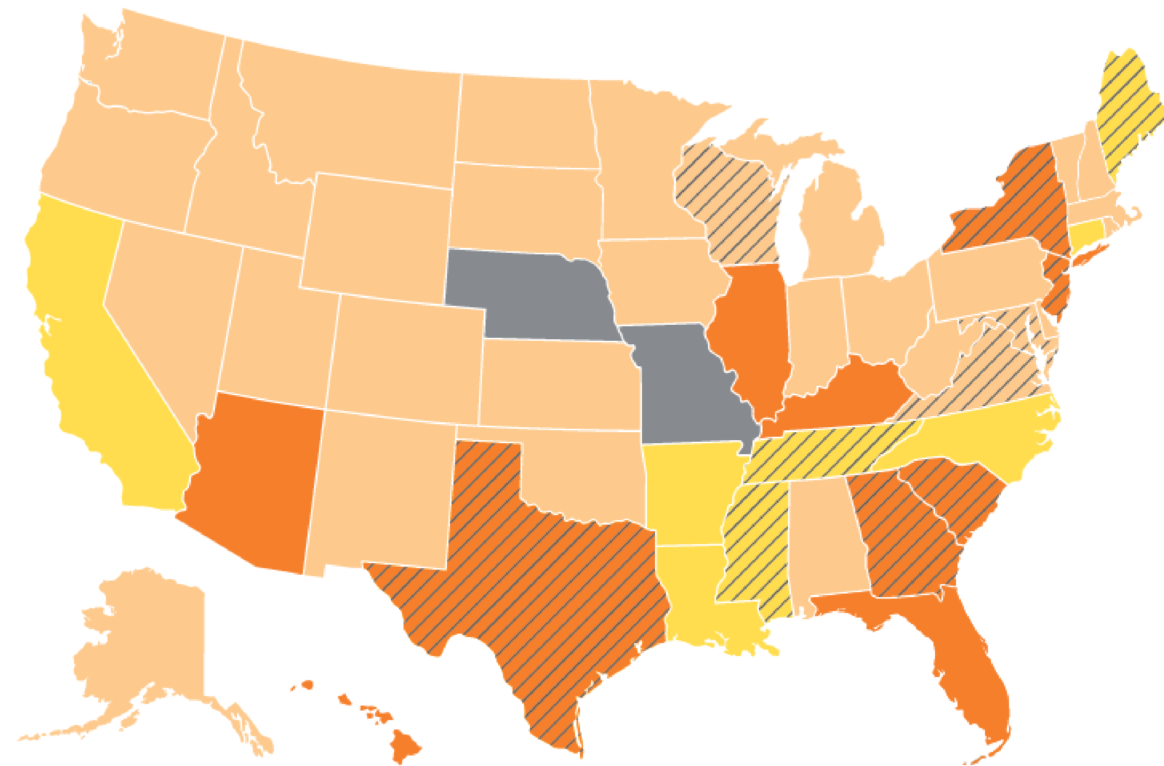
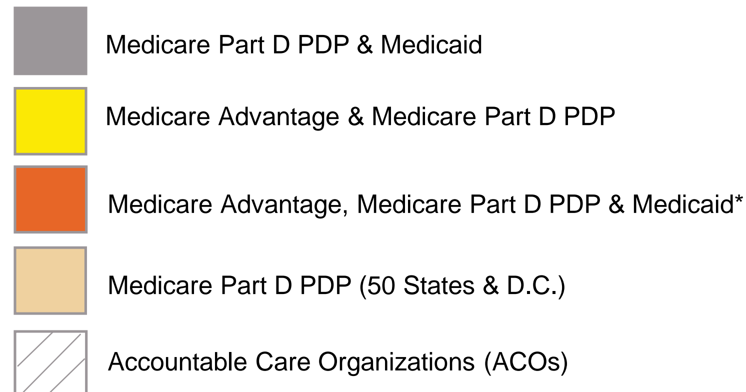
Beyond Healthcare. A Better You.

Company Snapshot





*Includes states where the company receives Medicaid and Medicare revenues associated with Dual Eligible Special Needs Plans (D-SNPs)

All numbers are as of March 31, 2018

Founded in 1985 in Tampa, Florida:
- Serving 4.3 million members nationwide
- 526,000 contracted healthcare providers
- 68,000 contracted pharmacies

Serving 2.7 million Medicaid members in 12 states:
- Aged, Blind and Disabled (ABD)
- Intellectual Developmental Disabilities (IDD)
- Children's Health Insurance Program (CHIP)
- Family Health Plus (FHP)
- Supplemental Security Income (SSI)
- Temporary Assistance for Needy Families (TANF)

Serving Medicare members in 18 states:
- 506,000 Medicare Advantage members
- 1.1 million Prescription Drug Plan (PDP) members
- 18 Accountable Care Organizations (ACOs)

Serving the full spectrum of member needs:
- Dual-eligible populations (Medicare and Medicaid)
- Managed Long Term Services and Supports (MLTSS)

Spearheading philanthropic efforts in local communities:
- The WellCare Community Foundation
- WellCare Associate Volunteer Efforts (WAVE)
- WellCare Center for CommUnity Impact

Significant contributor to the national economy:
- 9,100 associates nationwide
- Offices in all states where the company provides managed care
- A Fortune World's Most Admired Company ranked #195 on the Fortune 500

WellCare's Approach

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At WellCare, we help reduce costs and improve quality and access for government health programs by embedding ourselves in the communities we serve.

The core elements below contribute to our value proposition:

Value Based Contracting Progression Timeline

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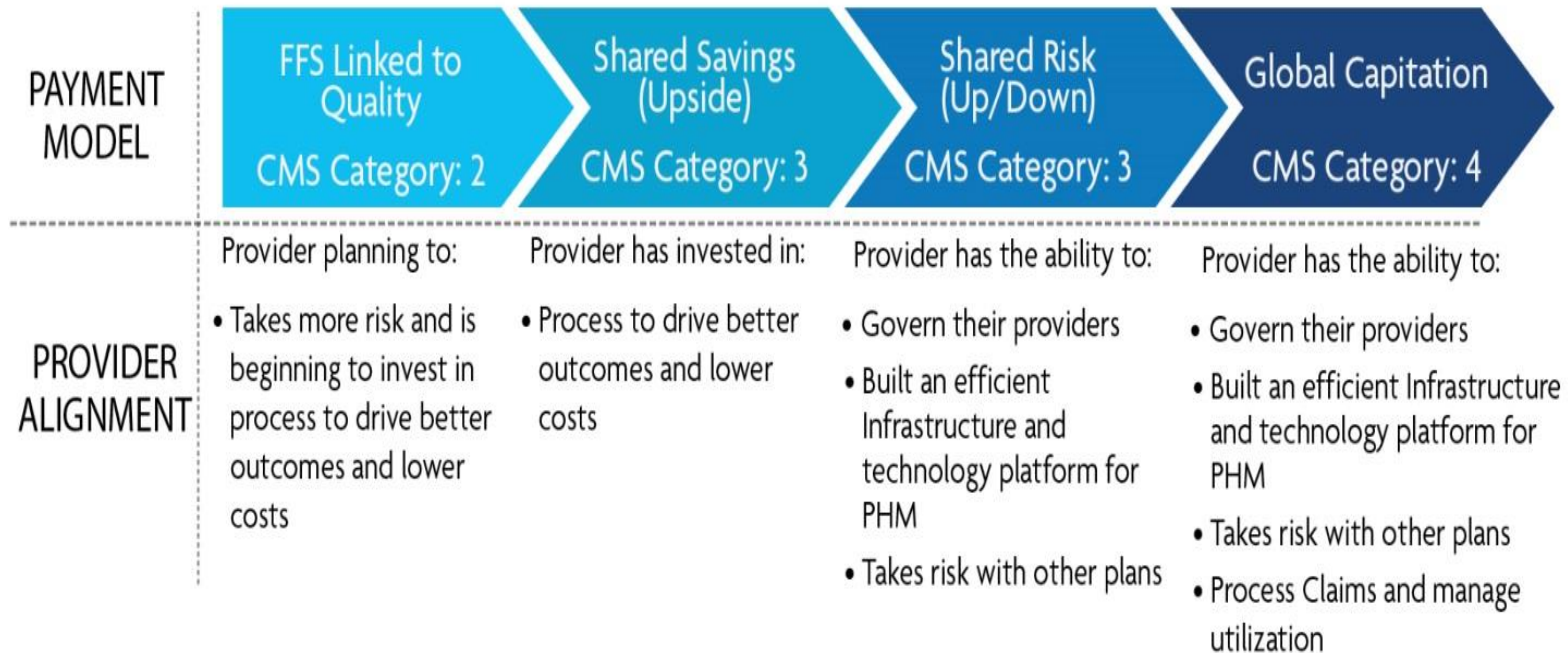

WellCare Strategy for Value Based Reimbursement

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Our strategy supports CMS and State goals:

- Level 1 (P4Q): Bonuses for quality-related activities and/or care gap closure; no additional meaningful financial exposure (upside or downside).
- Level 2 (Upside-Only Shared Savings): Begin to share in positive efficiency outcomes; incentives for quality performance.
- Level 3 (Shared Risk): Partial sharing in efficiency outcomes (positive or negative); greater potential rewards in exchange for greater financial risk; incentives for quality performance.
- Level 4 (Full Risk): Full financial accountability for efficiency outcomes (positive or negative); highest potential rewards given full financial risk; also responsible for quality metrics and population health outcomes (may link to efficiency risk / reward economics); in some cases, may include delegated operational functions.

Current Value Based Reimbursement Activities

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Level 1 and 2 activities:

- Integrated Behavioral Health Home – CMHC based- pmpm with FFS wrap around
- Pay for Performance on BH HEDIS Measures – bonus structure
- ED diversion program with quality metrics tied to the contract
- Incentive pay for medical and behavioral coordination
- Additional pmpm for meeting quality scorecard metric

Level 3 & 4 Activities:

- Risk capitated IPA and BH providers with significant delegated functions
- PCMH assignment (pmpm)
- Care Management delegation
- ACO Model full risk delegation

Challenges to Value Based Reimbursement

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Reasons why VBR has been slower to advance with Behavioral Health Providers:

- Health Plans focus on primary care VBR and take longer to develop programs for specialty providers
- Proving initial return on investment (ROI) is difficult
- No consistent agreement on what constitutes an “outcome”
- Historically no consistent agreement on what to measure
- Funding levels of VBR contracts not attractive enough to gain interest
- Difficulty finding providers who are ready to participate
- Start up money needed and technical assistance needed is higher than anticipated
- Ensuring data integrity and data completeness on both sides is accurate

Overcoming the Barriers and Impediments

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- Providers consider a phased approach
  - Year 1 pay for quality
  - Year 2 upside risk
  - Year 3 upside/ downside risk

- Health Plans support providers in different ways
  - Provider engagement model
  - Provider support with technical assistance (i.e. data management)
  - Provider education and tool box

- Achieve alignment and agreement on outcome measurements that are consistent across providers – use evidence based best practices not niche individual programs to incentivize

- Develop meaningful reimbursement structures to move away from FFS models

- Commitment to growth strategy including VBR structures

Steps To Prepare For Value Based Reimbursements

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Provider quality improvement measures and activities need to align with VBR programs- start now to address/implement these measures:

- Prevention and screening
- Access to care for physical and mental health conditions
- Management of chronic conditions such as HbA1c control, blood pressure control, medication adherence
- Improved birth outcomes
- Opportunities to reduce potentially preventable events
- Integration of physical and behavioral health

Starting with these areas of measurement ensures a common definition of success between WellCare, our providers, and state agencies.

Steps To Prepare For Value Based Reimbursements

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- Advance electronic health record capabilities and data analytics
- Improved member care experience through a more efficient, patient/member centered and coordinated system with less system fragmentation and less inpatient care and more integrated community-based care
- Move from a reactive, provider-focused system to a proactive, patient/member focused system
- Develop a collaborative process that reflects the needs of the populations we serve; care provided in the communities where our members live and all treating providers actually speak with each other
- Focus is on value to members, community and other stakeholders

Steps To Prepare For Value Based Reimbursements

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- Show collaborative behavior; communicate with all the providers that are treating your members and communicate with us
- Show us what you do measure — even if we don't ask
- Volunteer to pilot programs with us
- Be willing to share new ideas
- Be a "gold card provider" — not an outlier
- Educate your medical colleagues and allow them to educate you
- Be available to PCPs on their terms

Changes To Support Providers In Moving to VBR

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Health plans are changing how we interact with providers:

- Increasing transparency through data sharing and data analytics
- Technical assistance
- EMR/ EHR connectivity
- Real time connection to ED/ crisis member activity/ notification
- Education and training that focuses on integration, whole person care
- Access to our social determinant strategy- CommUnity Impact model

Figure 2: Provider Engagement Model

Changes To Support Providers In Moving to VBR

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Some of the data points we share with providers include:

- Medical, behavioral and pharmacy claims data
- Gaps in care across the continuum
- ED use, inclusive of all diagnoses
- Quality measures/graphs
- Readmission stats
- Newborn data
- E-prescribing data
- Cost of care/gain share
- Shared savings statistics

Negotiating A Value Based Contract

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- Remember health plans are fairly new at this too, and we don't have all the answers
- Building trust is essential – open dialogue, transparency and willingness to work together
- Share data and use data to inform our decisions
- Have realistic financial reimbursement expectations
- Be flexible and willing to change direction if what we are doing is not working
- Be willing to try pilots as big changes all at once may be too much
- Start with easy to define and easy to measure outcomes and build from there

Negotiating A Value Based Contract

- Understand your capabilities to meet the standards and performance requirements under a VBR structure
- Educate and train your teams on the requirements as the shift in business model is significant and internal culture change is required
- Accept and embrace that providers are going to be held to common performance standards and timelines where funding is directly tied to reaching mutually establish goals and that provider incentives are aligned with program goals and health plan goals
- Financially planning for the shift from FFS model to VBR model is necessary and consideration of capital investors, merger/ acquisition activities should be discussed

Information About Encounter Reporting By Providers

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- WellCare complies with all state and federal regulatory requirements regarding billing and encounter reporting practices
- Any VBR agreement that has case/bundled rate or capitation does require providers to encounter all service activity
- WellCare will establish an electronic file transfer relationship with providers
- Contracts include specific performance requirements that include encounter production. WellCare will assign staff to set up the process and provide technical assistance to providers
- WellCare maintains a provider website and provider portal that all contracted and credentialed providers can access for information and assistance