

Data and Finance Acuity in Managed Care

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VOICES

Objectives

- Brief update on 1115 waiver...
- Understand the business components that are “must have’s” for managed care
- Learn about costing, data capacity and contracting processes used by providers in a managed care network
- Gain practical tips on ensuring your organization conducts business functions that allow for alternative payment methods

Where are with the 1115 wavier?

Transition to the 1115 Waiver

Deliver whole-person care through coordinated physical health, behavioral health, intellectual/developmental disabilities and pharmacy products and care models

Address the full set of factors that impact health, uniting communities and health care systems

Perform localized care management at the site of care, in the home of community

Maintain broad provider participation by mitigating provider administrative burden

Standard Plan (SP) Bidders

- SP RFP was released in August
- 8 Responders were:
 - Aetna
 - AmeriHealth Caritas
 - BCBSNC – Healthy Blue
 - Carolina Complete Health (PLE)
 - My Health by Health Providers (PLE)
 - Optima Health
 - United Health Care
 - WellCare Health Plans



Common Themes

- Whole Person Care, including factors of social determinants of health
- Improve the experience of care, improve the health of populations and reduce per capita costs of health
- Decrease fragmentation, improve coordination of care and provide care which is appropriate and meets the needs (not just what is available)
- Transition to care delivery and payment arrangements that align quality and cost incentives

Commercial Plans and PLEs

- The CPs and PLEs (Prepaid Health Plans – PHPs) are in the state and working hard to build relationships and partnerships with the existing stakeholders
- They're hiring staff and establishing infrastructure, offices and working the political front – not any different than any company, provider, lme/mco - what are the pieces to get a competitive advantage
- They are also looking at building relationships with providers, starting to talk about philosophy and approaches
- Behavioral Health Services will be critical to all of the PHPs and you should be actively “at the table” with the bidders

Tailoring Programs to Align with State and Practice Needs

Our adaptable, customized solutions are easily transferrable between markets and maintain the ability to augment our value-based programs for state-specific initiatives.



We Know That Health is...

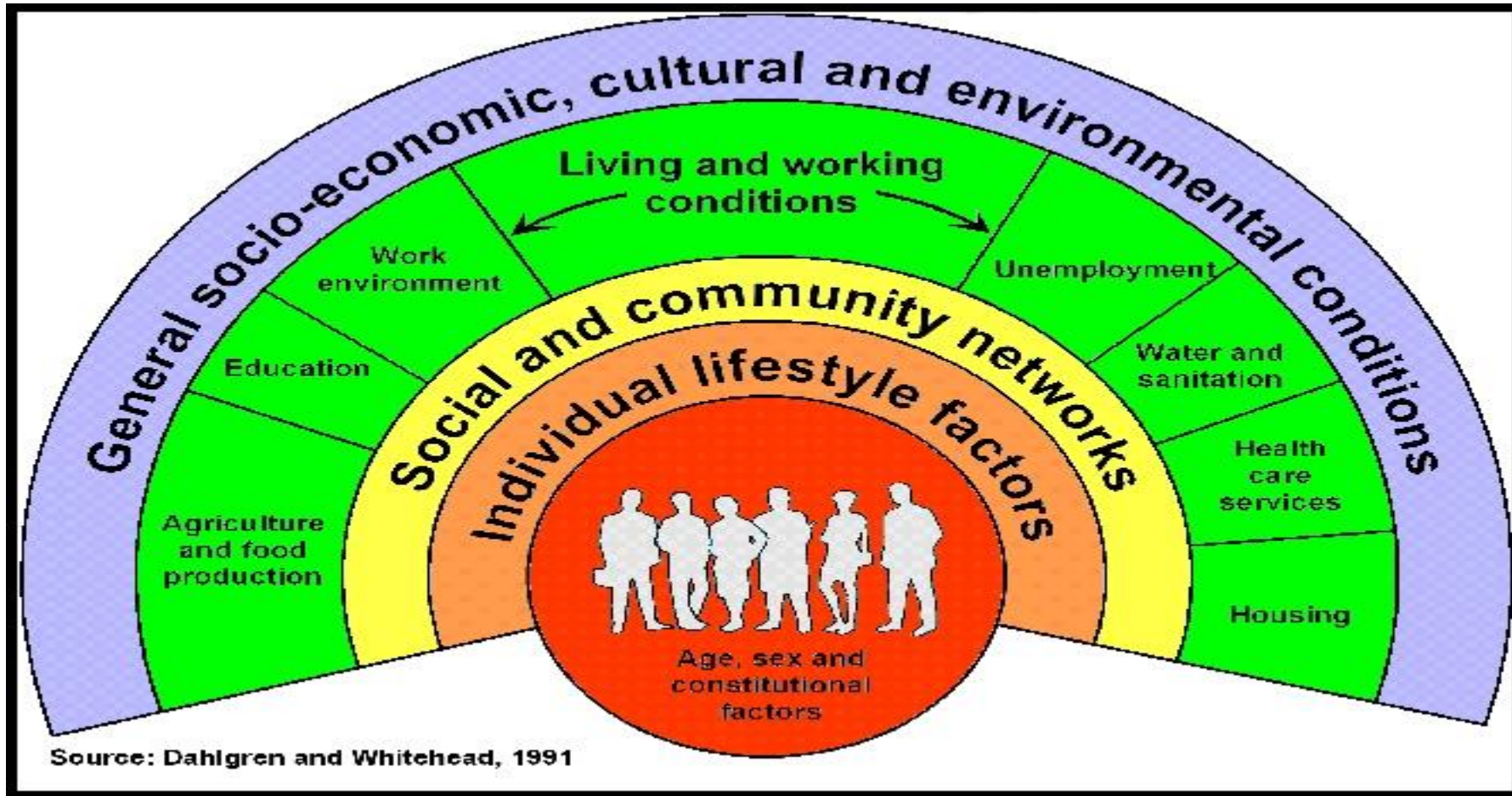


Figure 2

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment Income Expenses Debt Medical bills Support	Housing Transportation Safety Parks Playgrounds Walkability	Literacy Language Early childhood education Vocational training Higher education	Hunger Access to healthy options	Social integration Support systems Community engagement Discrimination	Health coverage Provider availability Provider linguistic and cultural competency Quality of care

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

1115 Healthy Opportunity Pilots

- Two to four regions to improve health and reduce health care costs
- Working with plans to identify cost effective, evidence based strategies focused on:
 - Housing
 - Food
 - Transportation
 - Employment
 - Personal Safety
- Will link payments to improvements in outcomes and efficiency
- Will use rapid-cycle assessment strategy

Must Have's...

Key Factors in Operational expectations

- Cost of Services... are you at risk today? can you accept risk tomorrow?
- Information Systems... Electronic Medical Record... ability to share data in “real time”?
- Sophistication in developing contracts...
- Ability to adapt to alternative payment models...
- Ability to work with other Care Coordinators...

Considerations for Providers working with MCOs/PHPs

- An ability to manage their cost of services in a way that they can create a profit based on the payment that the MCO is proposing to pay them for their services. Or, can the provider(s) develop a new model of service delivery and in turn creates a new payment structure that allows the MCO to have better outcomes and in the longer term lower cost, and/or greater control over future growth in their cost.
- An ability to negotiate contracts with the MCO. The MCO most likely has a greater team of lawyers than most providers. However, the provider needs to understand how to set themselves apart, define their strengths and be able to negotiate a better contract.
- An ability to work with Care Coordinators. Most MCOs are developing their own teams to provide care coordination. The provider will need to prove their value and be able to work alongside the MCOs care coordinators in helping them achieve the goals they have set for their members.

Building the Infrastructure

- AMH Model
- Your Relationship with Primary Care
 - Screening
 - Referrals
- Service Offering and Timely Access
- Sharing of data and follow up on findings and intervention
- Selecting the payment model



Data, Cost & Contracts...

Shared Goals and Better Outcomes

Providers



Payers

- Showing Value
- Knowing people are getting better but can't prove it, no data
- Available data doesn't tell the real story
- Can't afford the requirements

- Paying for Value
- Have lots of data and don't know if people are getting better
- Available data doesn't tell the story
- Can't afford the cost

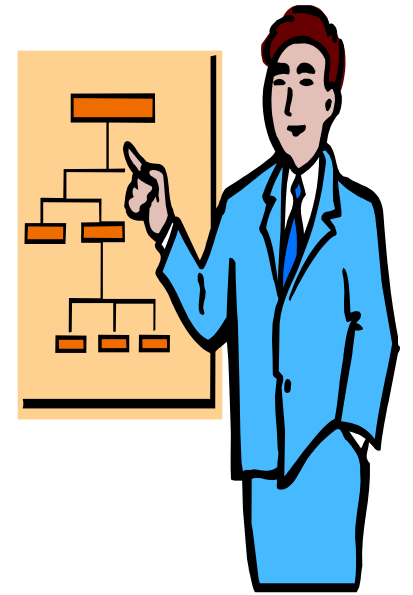


What are the common denominators to the factors related to sustainability of the Provider of Value?

- **DATA and Systematic Analysis**
- **Being able to achieve market share**
- **Providing services that will produce desired outcomes**
- **Meet the needs of the purchaser**

Data Sources Today and Their Use

- Most data sources in today's market are claims based
- Limited behavioral health sites are pulling information from EHRs or other case management systems
- In order for true whole person care to happen, data sharing and integration must be more "real time.:"
- Being used for
 - Population Management
 - Financial and Forecasting
 - Benchmarks and Outcomes
 - Provider Management and Performance ratings



Provider Considerations

- What gets measured is what gets done
 - Do you know what the plans or the State is requiring?
- P4P or VBS WILL change practice patterns, service delivery so make sure the “value” is how you want the system to change.
- THERE WILL BE THE NEED FOR LITERACY TRAINING – ACROSS THE ORGANIZATION
- Metrics will drive both what is “good” and “bad” behavior

Provider Consideration

- Failure to align the metrics with the vital business/programmatic functions
 - Market changes
 - Staff change
 - Performance requirements
 - Consumer/member expectations
- Metrics should be used with the strategic plan, implementation of the MC rules, the gap/analysis
- Start with outcome then reverse engineer milestone process and performance
- Success won't be measured just by what you do

Being a Provider of Value



Definitions of Value Based

- Linking provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers.
- Healthcare delivery model in which providers, including hospitals and physicians, are paid based on patient health outcomes. Under value-based care agreements, providers are rewarded for helping patients improve their health, reduce the effects and incidence of chronic disease, and live healthier lives in an evidence-based way.

What Does the 1115 Waiver say about VBP?

PHPs are required and incentivized to develop and lead innovative strategies to increase the use of VBP arrangements over time arrangements that appropriately incentivize providers and are required to submit their VBP strategies to DHHS and report on their use of VBP contracting arrangements each year.

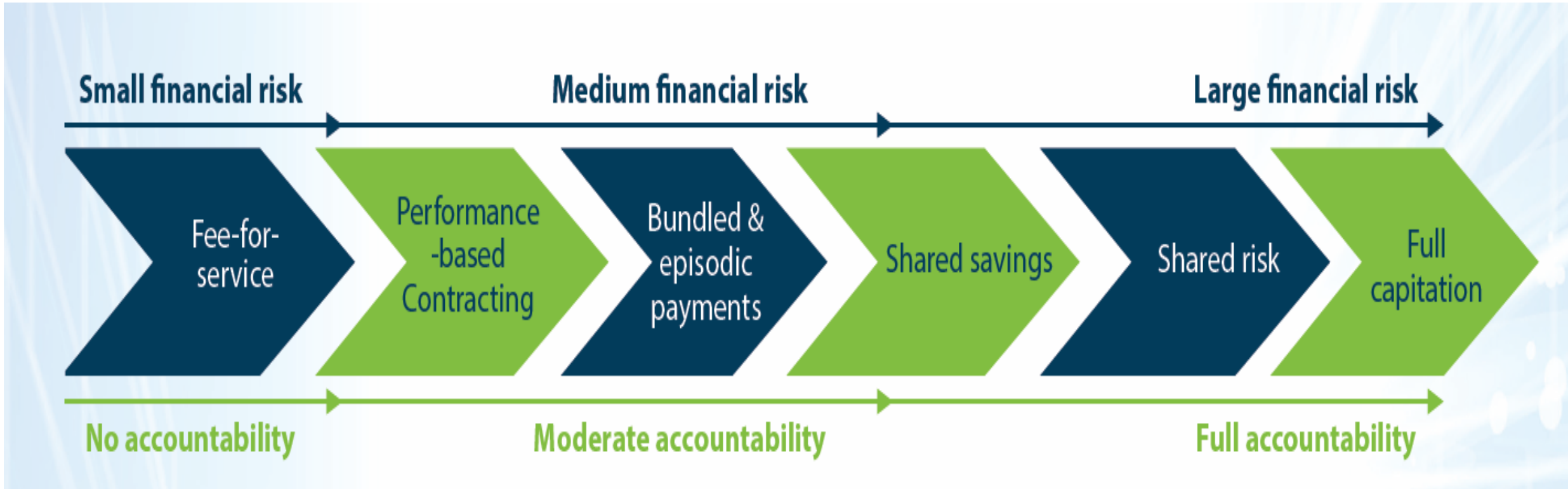
DHHS has defined VBP – for the first two years of PHP operations as payment arrangements that meet the criteria of the Health Care Payment (HCP) Learning and Action Network (LAN) Advanced Payment Model (APM) Categories 2 through 4. (NC Quality Strategy)

Value In Health Care

- “Value in health care is measured by the outcomes achieved, not the volume of services delivered, and shifting focus from volume to value is a central challenge”
Michael Porter
- “Value can be defined as patient outcomes divided by total cost per patient over time”
Institute of Medicine



Models of Value Based Contracting



- Increasing Risk
- Increasing Accountability
- Health Care Payment Learning and Action Network (HCP-LAN) Advanced Payment Model Framework.

Alternative Payment Model Framework



Category 1

Fee for Service –
No Link to
Quality & Value



Category 2

Fee for Service –
Link to
Quality & Value



Category 3

APMs Built on
Fee-for-Service
Architecture



Category 4

Population-Based
Payment

A

Foundational Payments for
Infrastructure & Operations

B

Pay for Reporting

C

Rewards for Performance

D

Rewards and Penalties
for Performance

A

APMs with
Upside Gainsharing

B

APMs with Upside
Gainsharing/Downside Risk

A

Condition-Specific
Population-Based Payment

B

Comprehensive
Population-Based
Payment

How Payments are made

- What level of the APMF are you striving for?
- Think about
 - Withholds/penalties that the SP/TP are under?
- What payment structure works best for your model?
 - Bundled payments
 - Episode of care
 - Shared savings

How Payments are made?

- Not unusual to phase in VBP/P4P
 - Participation reporting structural with FFS/CR
 - Participation in process measures in FFS/CR
 - Payment for meeting process/outcomes with assuming some level of risk
- Higher rates for service
- Practice improvement payments
- Year end bonus
- Expanding service array with payment thresholds
 - 80% of rate
 - 20% for utilization goal
 - 10% outcome goal
 - Yes, getting paid 110% of FFS arrangement



Utilization of Financial Data

- Identification of high cost/high risk consumers (Target Services/Payments)
- Identification of Access Barriers/Cost to Address
- Costs/Service Authorizations/Outcomes
- Combine Financial Data with Outcome Measures

Opportunities

- Must know how to calculate cost (not payment) to move to APMs.
- Track average cost of care per service line
- Use data to develop a value proposition – PHPs will do a readiness review before applying APMs
- Explore partnership opportunities with larger primary care practices

Basic Financial Analytics

- Key Element to Data Driven Organization
- Use Data Readily Available to All Providers
- Provides Powerful Foundation For Service Management/Program Monitoring/Dash Board Reporting
- Critical Tool to Frame TP/SP Discussions
- Enables Provider to Rise Above the Competition or to at least understand market share
- Supports Identification/Management of Financial Risk
- Must be Paired with Workload/Service Management/Outcome Data



Moving to the Next Financial Level

- Most people think direct and indirect cost – overhead and administration
- Do you know your:
 - Total cost per patient
 - Cost per complex patient
 - Cost per visit or episode of care
 - Change in net assets to expense ratio
 - Working capital to monthly expense ratio
 - Long term debt to equity ratio
 - Cost of workflows in place
- Need this level of detail before deciding on APMF payment



Utilization of Financial Data

- Enhanced Rates
- Incentive Payments
- Non-UCR Support/funding mix
- Increased Access Capacity Support
- Paying for Availability
- Pay for Performance
- Shared Savings/Shared Risk



Summary: Being a Provider of Value

- Alternative Payment Models will be used transitioning on/from a FFS foundation
- FFS will get used first with quality and outcome component
- Prepare for assuming risk
- Increase degree of integration, risk and accountability
- Actionable DATA and data exchange
- Evidence of effectiveness
- Provider infrastructure and economies of scale

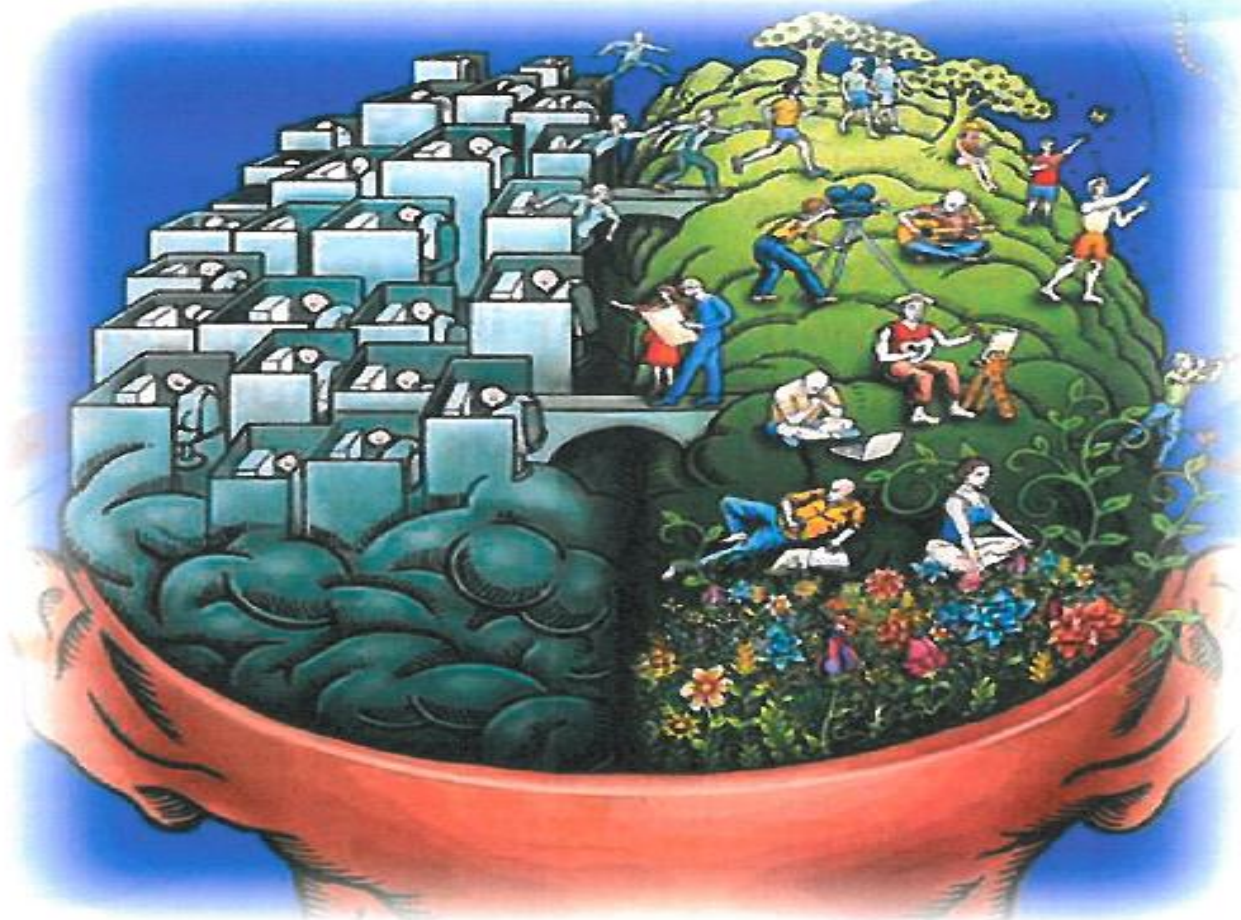
Practical Tips...

To recap...Where are we going??

- Currently, our systems focuses on treating people who are sick or in need of supports, reacting to problems or symptoms
- The more we serve, the more units, the more money we receive – we appear “better” and doing our job
- We’re moving to a system that is looking at revenue based on value, not on number of units or encounters provided only
- Trying to be proactive and PREDICT
- Looking at
 - Quality
 - Efficiency
 - Satisfaction



BEAN COUNTER



POET

Provider Sustainability in the Managed Care Environment

- Identification of needs in the community and developing the appropriate program and services the SP/TP will BUY
- Have an EHR and/or a way to provide data electronically
- Establish sustainable funding and manage expenditures in P4P or VBP arrangements
- Determine the clinical or programmatic models that meet the organizational capacity of the agency
- Build a robust data system that connects outcomes, analytics, billing and collection infrastructure
- Improve the agency through a comparative analytical processes – know the market share

Next Steps

- Assessing the existing strategic plan and making the necessary modifications for the future role
- Identifying the resources and action steps to carry out the plan
 - REASONABLE
 - Not compromising the quality of care activities that the agency is known for today
 - All within an ever changing environment



Suggestions for project work in Fiscal Year 2018??

- Managing the episode of care??
- Value based payment plans??
- Alternative payment models??
- Starting small with population health management??
- What else?????

Opportunities

- Partnerships with health plans to be an early adopter of value-based contracting using alternative payment models
- New revenue streams through leveraging expertise in motivational interviewing, behavior change and person-centered thinking to assist/partner with primary care and Advanced Medical Home to help them realize incentives

How to Prepare for the Future

- How can you take what you do and leverage expertise to evolve in the IDD health community? `
- How do you capture a move in the child arena for children and their families involved with DSS?
- Do you want to move in the Long Term Services and Supports (LTSS) arena? It is not just the IDD field

Your Value to the System?

- There will continue to be a push for more community based services, less residential
 - Does NOT mean everything closes...at this point
 - New in lieu of definitions
- Expectations:
 - Services for people with autism
 - Services for Dually Diagnosed (IDD/MH or SU)
 - Coordinated/Integrated care with primary care
- Referral to providers for TARGETED CASE MANAGEMENT for those children identified in a settlement agreement with Disability Rights Ability to operate under arrangements of alternative funding, greater scrutiny of cost, ROI (return on investment) and Medicaid block granting currently in the Congress' replacement plan for ACA (Obamacare)
 - Financial Analysis and robust metrics are required for P4P and other payment arrangements

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Competing on Integration: WILL BE A MEASURE!!

SAMHSA-HRSA's Center for Integrated Care: Six Levels of Collaboration/Integration

COORDINATED Key Element: Communication		CO-LOCATED Key Element: Physical Proximity		INTEGRATED Key Element: Practice Change	
Level 1: Minimal Collaboration	Level 2: Basic Collaboration at a Distance	LEVEL 3: Basic Collaboration Onsite	LEVEL 4: Close Collaboration Onsite with Some System Integration	LEVEL 5: Close Collaboration Approaching an Integrated Practice	LEVEL 6: Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care, and other health care providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
<ul style="list-style-type: none"> • Have separate systems • Communicate about cases only rarely and under compelling circumstances • Communicate, driven by provider need • May never meet in person • Have limited understanding of each other's roles 	<ul style="list-style-type: none"> • Have separate systems • Communicate periodically about shared patients • Communicate, driven by specific patient issues • May meet as part of a larger community • Appreciate each other's roles as resources 	<ul style="list-style-type: none"> • Have separate systems • Communicate regularly about share patients, by phone or e-mail • Collaborate, driven by need for each other's services and more reliable referral • Meet occasionally to discuss cases due to close proximity • Feel part of a larger yet ill-defined team 	<ul style="list-style-type: none"> • Share some systems, like scheduling or medical records • Communicate in person as needed • Collaborate, driven by need for consultation and coordinated plans for difficult patients • Have regular face-to-face interactions about some patients • Have a basic understanding of roles and culture 	<ul style="list-style-type: none"> • Actively seek system solutions together or develop workarounds • Communicate frequently in person • Collaborate, driven by desire to be a member of the care team • Have regular team meetings to discuss overall patient care and specific patient issues • Have an in-depth understanding of roles and culture 	<ul style="list-style-type: none"> • Have resolved most or all system issues • Communicate consistently at the system, team, and individual levels • Collaborate, driven by shared concept of team care • Have formal and informal meetings to support integrated model of care • Have roles and cultures that blur or blend

Shared Business Processes??



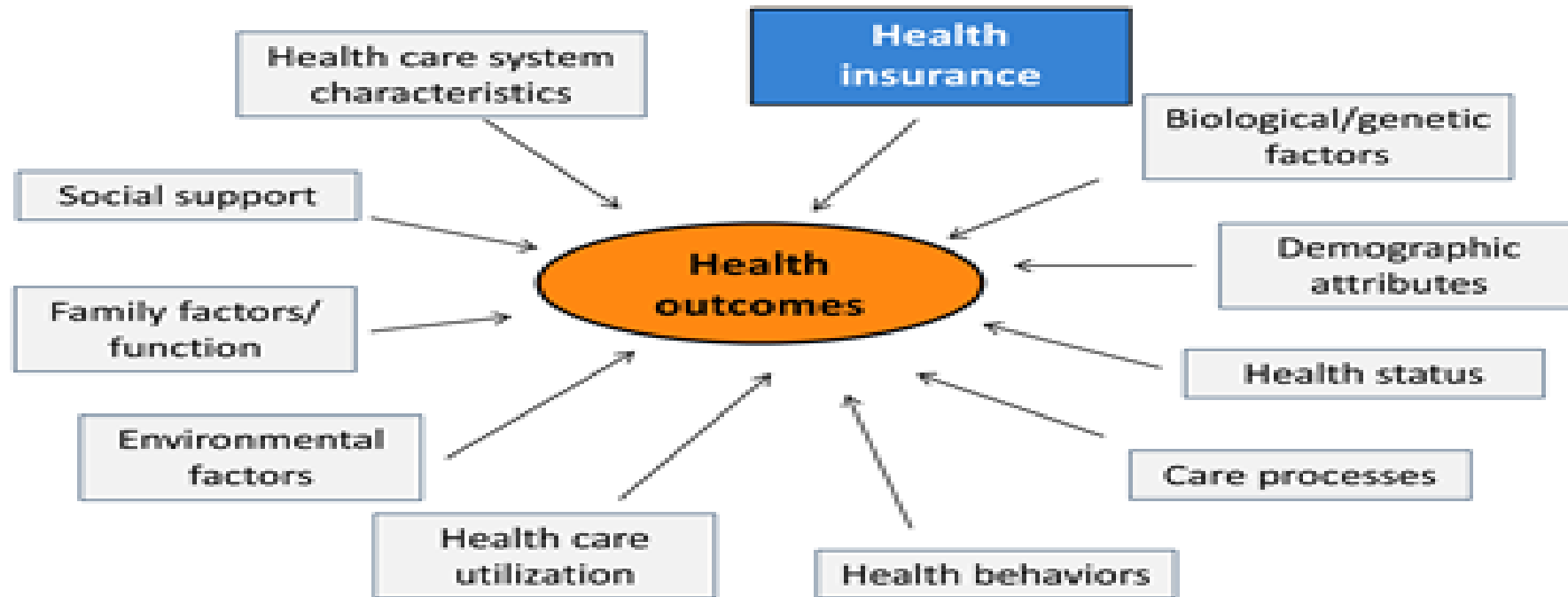
MANAGEMENT CONTRACTS??



We Know That...

Figure 1

Health insurance is one of many factors that contribute to health outcomes.

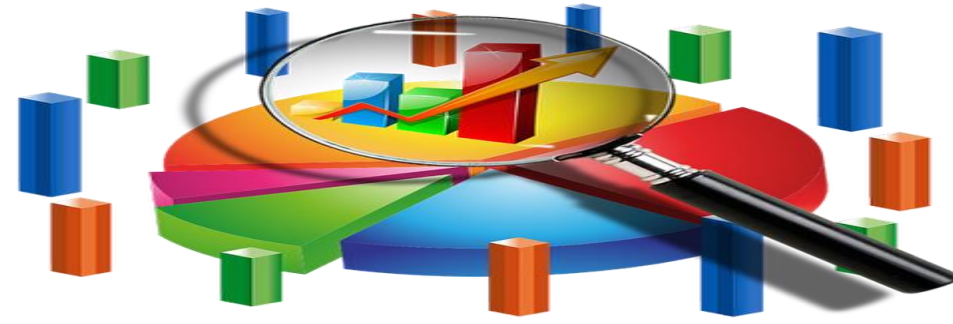


Recent Headlines from various articles... *Open Minds publication*

M&A in your future...

While there is a great deal of uncertainty about the future of health and human services, a couple trends are clear—more “integration”, more reimbursement based on value, and more consolidation. We are seeing a wide range of mergers, acquisitions, collaborations, and new partnership models. The reasons are straightforward—future competitive positioning and financial sustainability in the face of big system changes.... *Open Minds publication 10/4/18*

So Where to Begin



- **THINK BIG** – know where you're going
“You can't build a reputation on what you are going to do unless you actually do it” Henry Ford
- **BUT START SMALL** with implementation steps
 - have in place a process for measurement of success and need of improvement
- But do **NOT** sit still if you're going to be a provider of value

Up to Your Knees, or Up to Your Neck? Ask Yourself...

How Far Do You Want to Get In?

What is our current business strategy?

What is our level of diversification?

Do we have capacity to grow or expand?

Can we partner or affiliate with others?

Do we have energy to take it all on?

Are our clinical teams and business teams equally **knowledgeable** of and **committed** to the strategy?

Are we prepared to embrace RISK?

Don't Sink...



Questions



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