CENTER *for* INTEGRATIVE HEALTH

insight to innovation

Convene.
Strategize.
Activate.

Provider Success Symposium

December 4, 2018

VISIONARY VOICES

Presenters

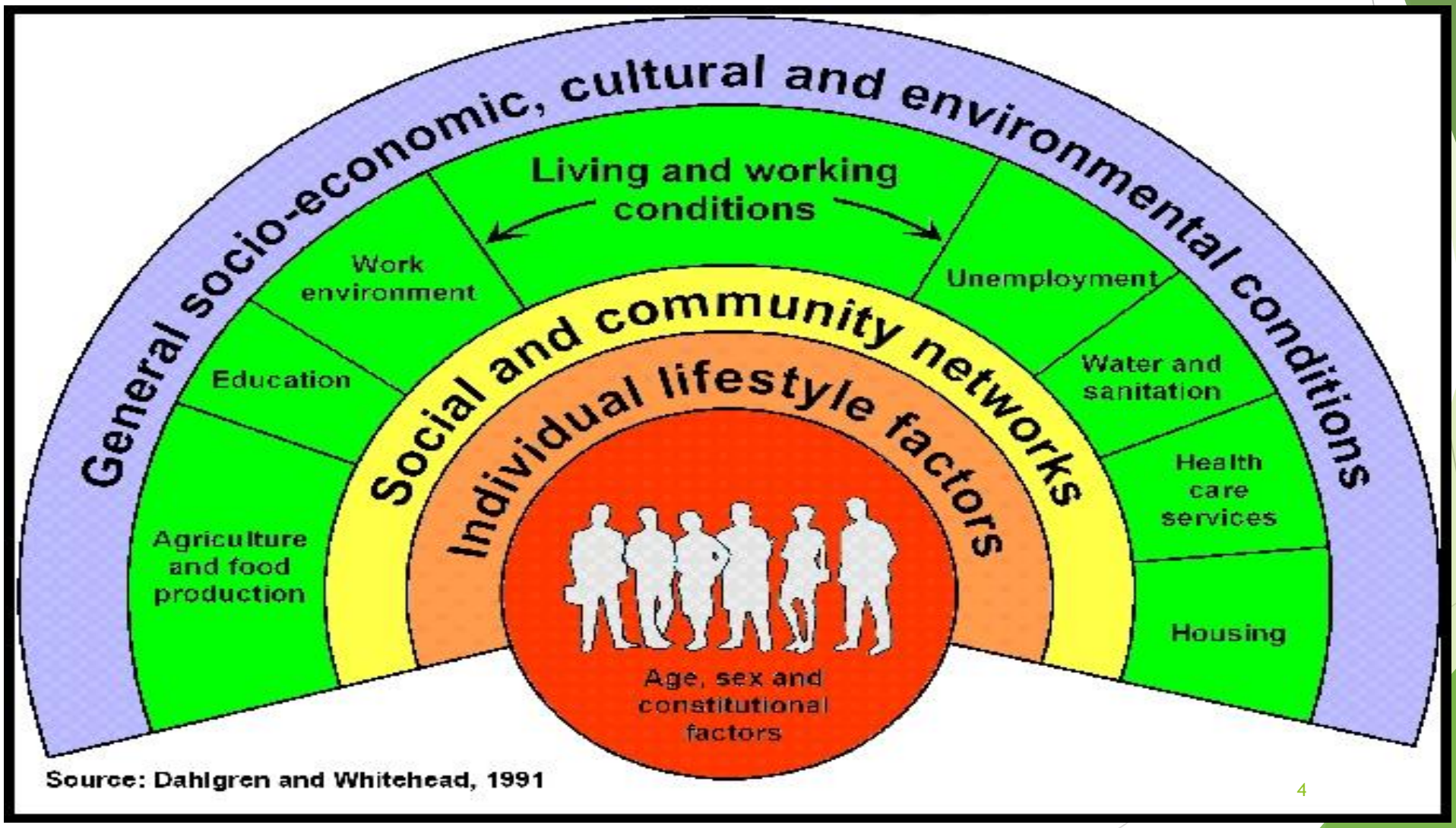
- Tara R Larson, Vice President, Cansler Collaborative Resources, Inc.
- Billy West, MSW, LCSW, President and CEO, Daymark Recovery Services
- Paul Enderson, Executive Director, Youth Villages
- Lindsey Crouse-Martin, Director of Value Based Care, AmeriHealth Caritas

Goals and Agenda

1. Understand what being a value based provider as defined by health plans means;
2. Understand the use of Electronic Health Records (EHR), connectivity to NC Health Information Exchanges (HIE), and how to use this data once it is flowing bi-directionally;
3. Identification of the infrastructure you must have for data collection, reporting and analysis to meet quality indicators that will be dictated by multiple payer sources;
4. Familiarization with the Alternative Payment Continuum including the tracking of costs in order to mitigate your financial risk;
5. Practicing WHOLE person care and understanding that it is not as simple as integrated behavioral health and primary healthcare.

Presentations and then questions/answers and discussion

We Know That Health is…




FUTURE IS NOW

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

The Standard Plan and the Tailored Plan

- The 1115 waiver options offers Standard Plan (SP) and Tailored Plan (TP)
  - SPs will be the default plan for most Medicaid recipients. SPs will be operated by Commercial Plans (CPs) and Provider Lead Entities (PLEs).
  - TPs will be the specialty plan for certain behavioral health/IDD individuals and possibly children involved with DSS (to be decided)
    - Be familiar with the criteria for "assignment" to which plan level
    - There are similarities of requirements and structure for each - TP or SP
  - Need to know what services are offered under each and what the population is under each?

Common Themes in Managed Care

- 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

- **The question is how are measures and "value" defined and outlined to meet these themes.**

What Does the 1115 Waiver and Standard Plan RFP Say about Value Payments ?

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)

- **By end of contract year 2, PHP expenditures with either increase by 20% or represent 50% of total medical expenditures**

Being a Provider of Value as Defined by the Payer and the 1115 Waiver

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”

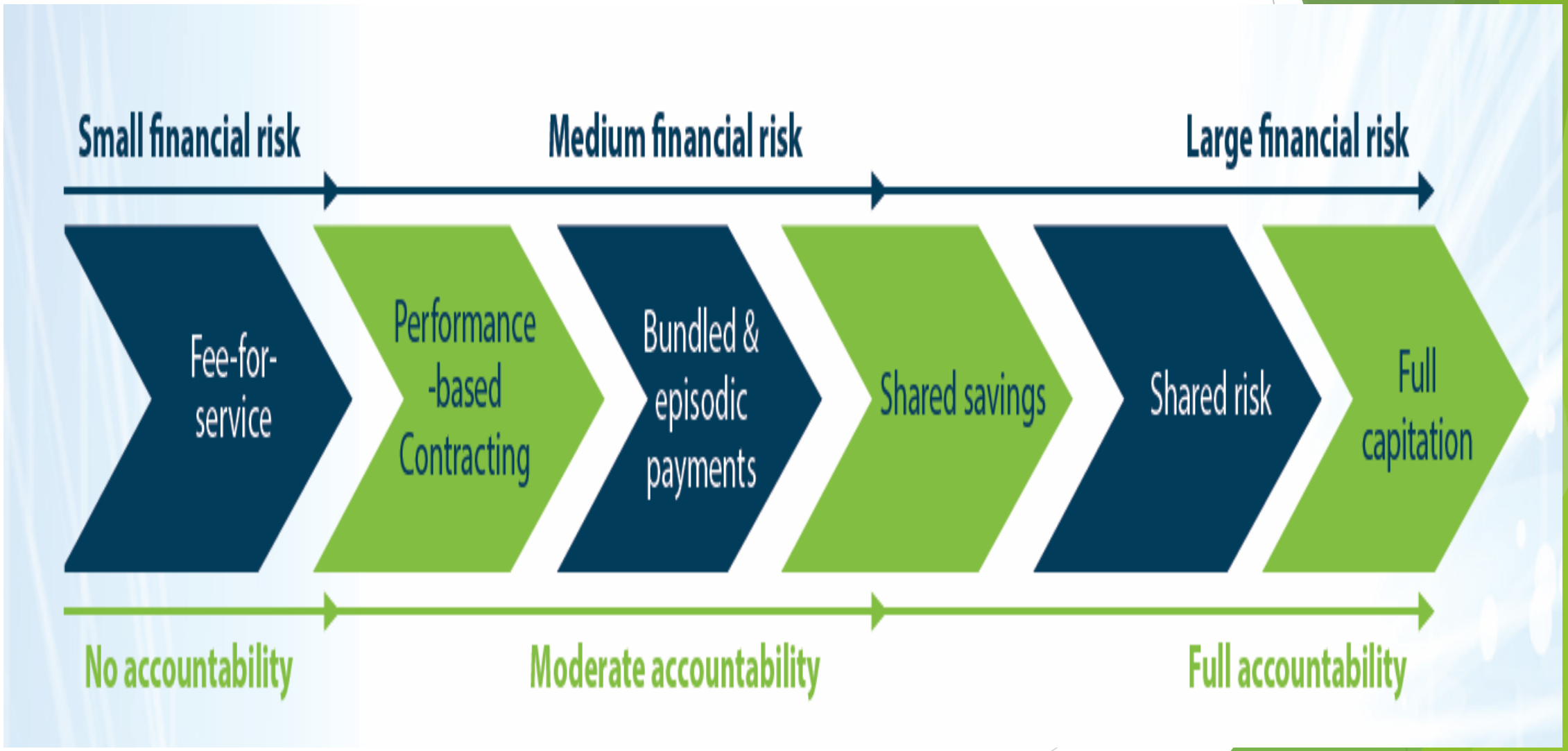
  Michael Porter

- “Value can be defined as patient outcomes divided by total cost per patient over time”

  Institute of Medicine

Alternative Payment Model Framework

Models of Value Based Contracting



Required PHP Quality Metrics: Standard Plan

- Section VII, Attachment E. Required PHP Quality Metrics, Page 37-54
  - https://files.nc.gov/ncdhhs/30-19029-DHB-2.pdf
- There are measures that are priority measures and those that also have withholds: Financial penalties.
  - Can you help the PHP/SP meet the measures?
- In addition to the measures, there are additional reporting requirements.
- Examples

How Payments are made

- What level of the APMF are you striving for?
- Think about
  - Withholds/penalties that the SP/TP are under?
  - Can you help them achieve their contract requirements with the State?
- What payment structure works best for your model or WHAT IS BEING BOUGHT?
  - FFS
  - Bundled payments
  - Episode of care
  - Shared savings
  - Combinations

As You Hear from the Presenters

- As a Board Member, As a MCO of a SP or TP, as a CFAC member, as a provide – what are the questions from your perspective?
- What are the challenges/the opportunities and how are you positioned to move forward and implement?
- Know that Denial is not an option
- Hold your questions to the end when we're saving time for discussion and questions

Value Based Purchasing

Billy R. West, Jr., MSW, LCSW
President and CEO
Daymark Recovery Services, Inc.
December 4, 2018

What is our product?

What are the needs of our communities and what are the strengths of the agency?

Community Needs = Our Strengths:

- Psychiatry
- Crisis Continuums (walk-in, FBC,MCM)
- Evidenced Based Outpatient Treatment
- Technology (telehealth, integrated care)

Preparation for value based contracting

1. What is the cost of each service line?
2. How does the service help your payer?
3. How does the service help the patient?
4. How may payment be tied to outcomes?

Generating and Acting on Data

1. Outcomes data? Outcomes are elusive in NC and may be until how services are paid are changed.
2. Relational contracting? Unofficial term describing identified needs in a community where mutual outcomes are identified by the payer and provider. Overall goal is to tie performance to payment.

Examples of Relational Contracting (Summary)

Needs	Action	Data
On demand care for urgent, emergent and routine patients	Development walk-in clinics that can handle routine to IVC	Detail reporting on patient volume, outcomes and cost
Psychiatry	Develop access to psychiatric prescribers Agree on care model	Detail on volume, productivity, cost
EBT and Literature Based Care	Agree on model, types of treatments needed	Detail on volume, productivity, engagement and cost
Integrated Care Efforts	Co-location to technology integrated care	Merit Based Incentive Payment System (MIPS)

Reporting Examples (Summary)

Action Item	Outcome	Preparation Needed
On demand care	FY: 2018 28,195 walk-ins (nonsched) 5,667 ED Diversions (20%) 475 ED Referrals (1.69%)	Development and maintenance, pt. cost, pt. outcomes, technology build out (EMR, telehealth, Meaningful Use, MU)
Psychiatry	Pt. volume, prescribing patterns, PCP linkage, production, MIPS scores	Cost per MD, code, and patient Technology build out (EMR, telehealth, MU)
EBT and Literature Based Care	Improve engagement, productivity, keep patients in low cost service, MIPS scores	Patient volume, service volume by service, technology build out (EMR, telehealth, MU)
Integrated care	Ability to produce MIPS in one or more areas	EMR, telehealth, MU, MIPS

Setting the Table

Relational Contracting is designed to meet the needs of the community and payer while preparing for a system that will be more outcomes oriented. We did not build our Certified Health Record Technology (CEHRT) in a day but over 15 years.

Traditional outpatient agencies historically provide group and individual therapies that are not easily integrated into primary care with other healthcare entities, are appointment driven and very difficult to comply with national outcomes. Value based contracting will require promoting interoperability (PI) between agencies.

Through this contracting, the focus must be on using PI to increase the use of health information (HI) to drive down cost and increase quality.

Physical Health Outcomes (Whole Person Care)

Any licensed BH/SA professional was likely trained in whole person care. This is not a new concept.

Historical paper systems, canned EHRs through national technology vendors and payment models were not conducive to true whole person care.

Relational contracting requires us to overcome these traditional barriers and build a foundation for a system that will be more outcome oriented.

Support Professionals Practicing at the top of their license.

We know the cost of every service we provide by location, payer source and diagnosis.

Your EHR must be MU Certified. Moreover, the agency must use it to promote PI.

For example, Daymark is using CEHRT. The EHR is certified to measure 53 of the 64 Clinical Quality Measures (CQM). We are focusing on 9 of the CQM but have attested with CMS for 6, the max number allowed at this time.

Our 9 CQM

CMS68: Documentation of Current Medications in the Medical Record

CMS69: Preventative Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

CMS138: Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention

CMS147: Preventative Care and Screening: Influenza Immunization

CMS155: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

CMS156: Use of High Risk Medications in the Elderly

CMS161: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

Our 9 CQM- continued

CMS165: Controlling High Blood Pressure

CMS169: Bipolar Disorder and Major Depression: Appraisal for Alcohol or Chemical Substance Use

CMS177: Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

Note: Attestation in these areas require proof met by the software extracting data and sending it in prescriptive formats to CMS.

Key questions to prepare for value based contracting

Do services meet the needs of the community?

Are the cost of the services known by service, diagnosis, patient?

Are there current deliverables that can demonstrate value?

Do you have a MU Certified EHR that is in use and preparing for MIPS?

Doing What Matters Most

A LOOK AT OUTCOMES AND ALTERNATIVE PAYMENT METHODS

Youth VILLAGES®
The force for families

Know Your Product

- What is your program's target population?
- What is the goal of your program (i.e. how do you know it's working and accomplishing its purpose)?
- How long is your program's course of treatment (i.e. what is the length of stay range in which you expect to see a positive therapeutic effect)?
- What outcomes do you measure to demonstrate your program's positive effect?

Example: Our program targets transitional-aged adults ages 17-21. The primary goal of the program is to produce a young adult capable of living independently. The program's typical duration is 7-9 months. We measure the % of participants that 1) are living in a home environment, 2) are in school or working, and 3) are not in jail.

Outcomes

- What is an outcome? Need to differentiate between work processes (you did something) and actual consumer outcomes (something meaningful changed).

- Clearly define what is most meaningful AND measurable. Litmus test: would both your consumers and payers agree?

- Know the difference between Quantify and Qualify.
  - Quantify: Being able to measure (either by degree or yes/no evaluation) objectively
  - Qualify: Being able to measure subjectively

- Establish a cadence of measurement
  - In-treatment performance improvement (to modify treatment approach when lead measures indicate a problem)
  - Post-treatment follow-up (to determine lasting effect)

Effect of Scale

- How much does your program cost to achieve its desired outcome?
- How does that change with scale?
- At what points do you achieve 1) minimum sustainability and 2) an economy of scale that results in a reduction in cost while producing the same profit margin AND positive effect?

Alternative Payment Methods

- Fixed Rate, Interval: Fixed interval rate (weekly, monthly) based on treatment enrollment, but not quantity of contacts.
- Fixed Rate, Episodic: Fixed rate based on episode of care, regardless of LOS or quantity of contacts.
- Fixed Rate, Risk Based: Fixed interval rate adjusted to risk during enrollment.
- Fixed Rate, Performance Based: Penalties/rewards based on targeted outcomes.

Who Can I Contact If I Have Further Questions?

Contact Info:

Paul Enderson
paul.enderson@youthvillages.org

Delivering the Next **Generation** of Health Care

- **A Presentation for Bi-State Primary Care Association**

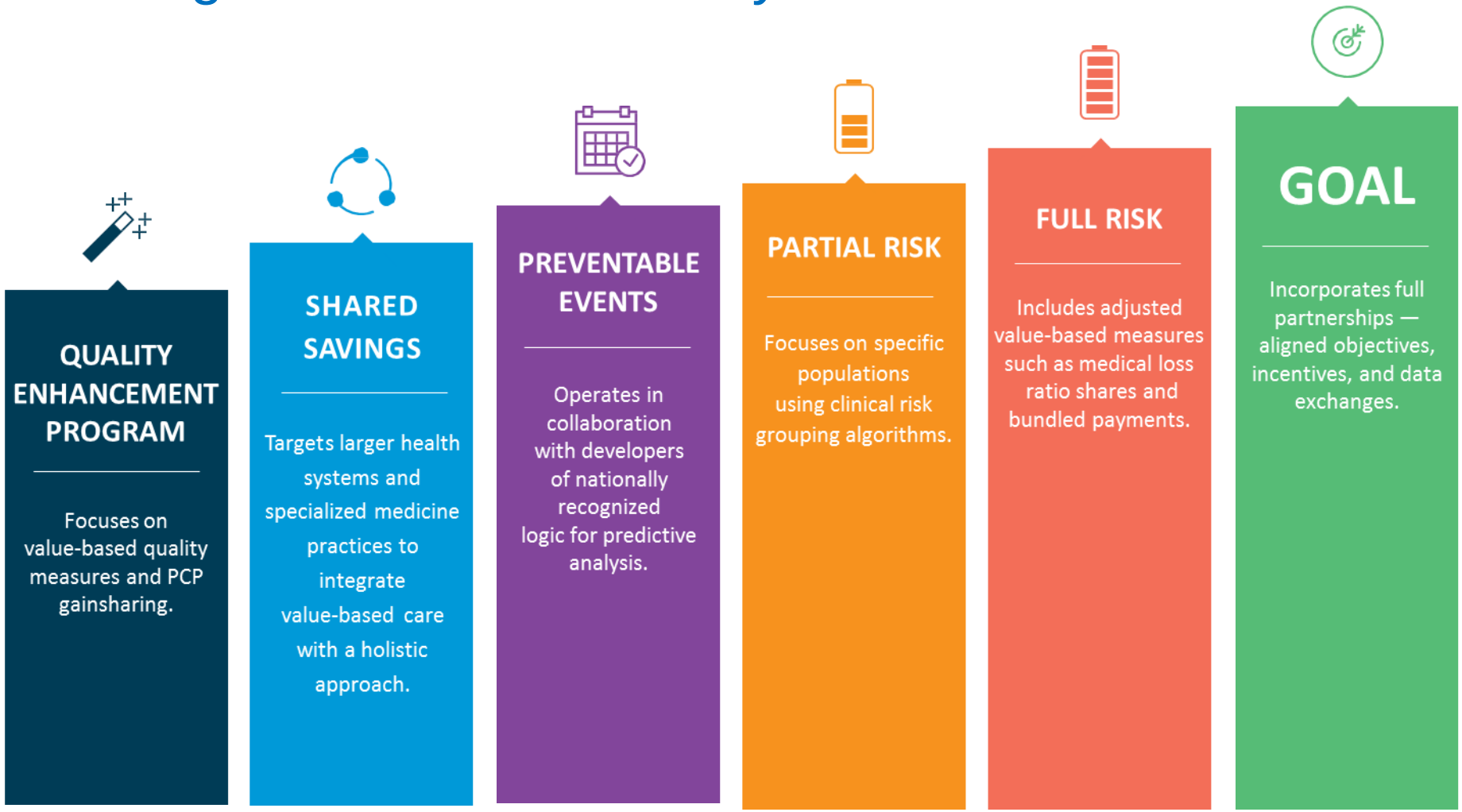
AmeriHealth Caritas

CARE IS THE HEART OF OUR WORK℠

December 2018

AmeriHealth Caritas
Value-Based Programs (VBP)

Transitioning to a Value-Based System



Partnering with Providers for Quality Improvement

AmeriHealth Caritas is leading the way in innovative payment methods, including opportunities to share savings through collaborative provider partnerships.

Our goal is to help providers maximize revenue and improving the quality of care resulting in positive patient outcomes.

A range of value-based purchasing models

CORE

- **Includes wide range of value-based models for PCP, OB/GYN, dental, and BH/IDD providers.**
- **Represents "upside only" financial potential.**

PREMIUM

- **Includes shared savings, specialty, bundle/episodic payments.**
- **Supported by advanced technology and analytic supports.**
- **Designed to support different levels of provider risk tolerance and sophistication.**

ELITE

- **Features increasing levels of fiscal responsibility and health system risk.**
- **May include risk-based collaboration and population health management.**
- **Expands beyond the typical structure of the health system.**

Achieving Growth in our Value-Based Programs

MEMBERS

1,989,082

ACTIVE

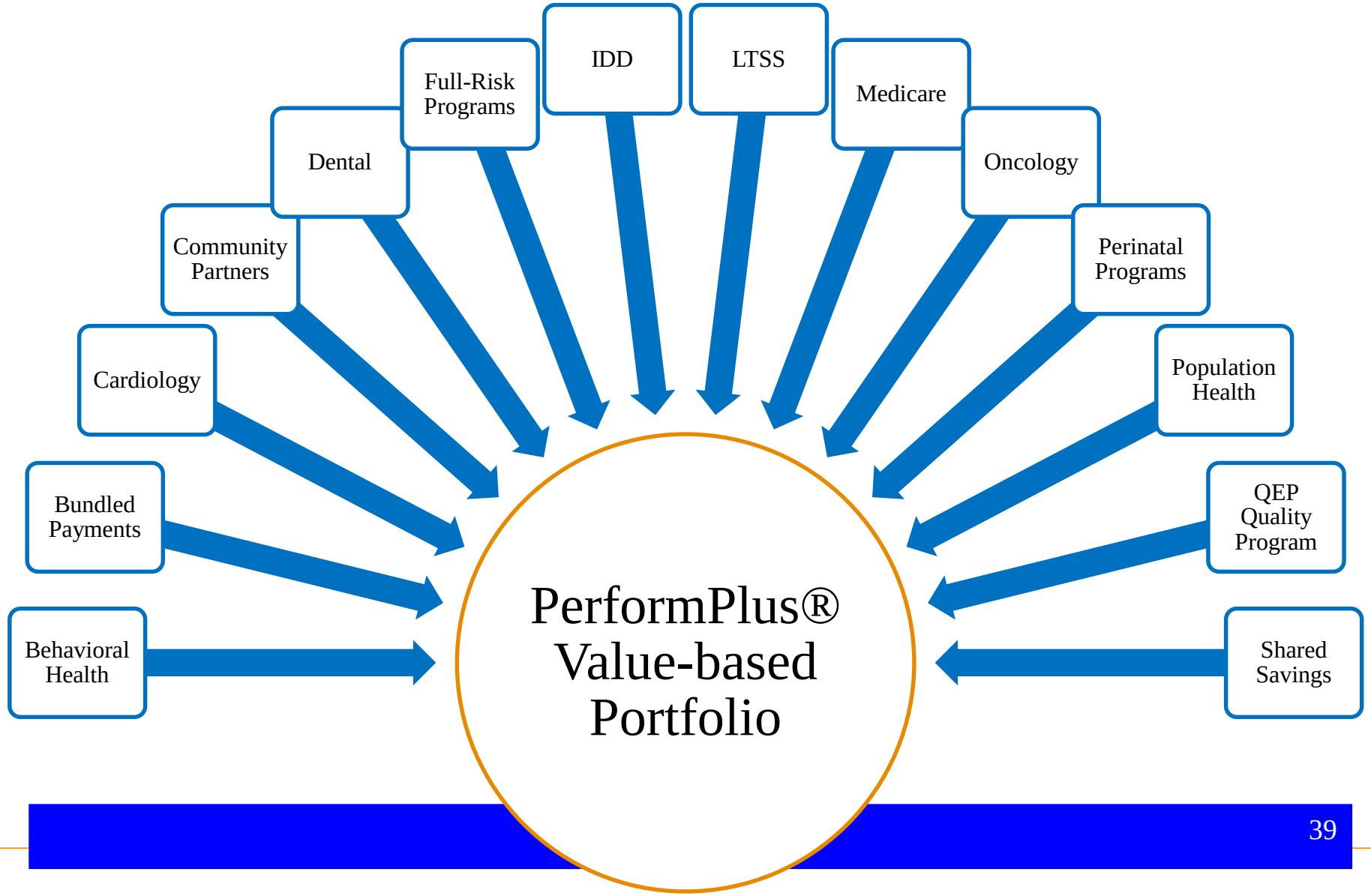
1,432,077

PERCENT BY MARKET

72%

As of August, 2018

Expanding Innovative Performance Programs



Engaging Different Types of Providers

Number and type of Providers participating in our Value Based Programs:

1,989,082 Members in Value-Based Programs	**2,544** Primary care physician groups	**66** Program partners spanning 6 states
22 Integrated delivery systems	**21** Federally Qualified Health Centers	**18** Specialized medicine provider groups

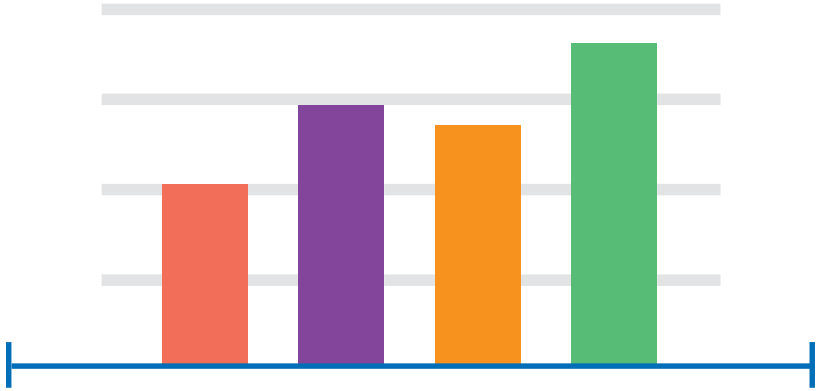
What Makes PerformPlus® Different?

- According to our current partners, the best features are flexibility, transparency, and multiple opportunities for success.

  - Unique focus on clinically preventable events.
  - Custom dashboards to provide you with the data and transparency you need to succeed.
  - Many opportunities for performance rewards within each program.
  - Peer-based and trend-based measures.
  - Programs tailored to your needs.
  - Excellent customer service and satisfaction.
  - Programs available for specialty groups.
  - Reliable risk adjustment.
  - Member and provider analytics (MPA) and self-service reporting.

VBP PerformPlus Dashboards and Data Sharing

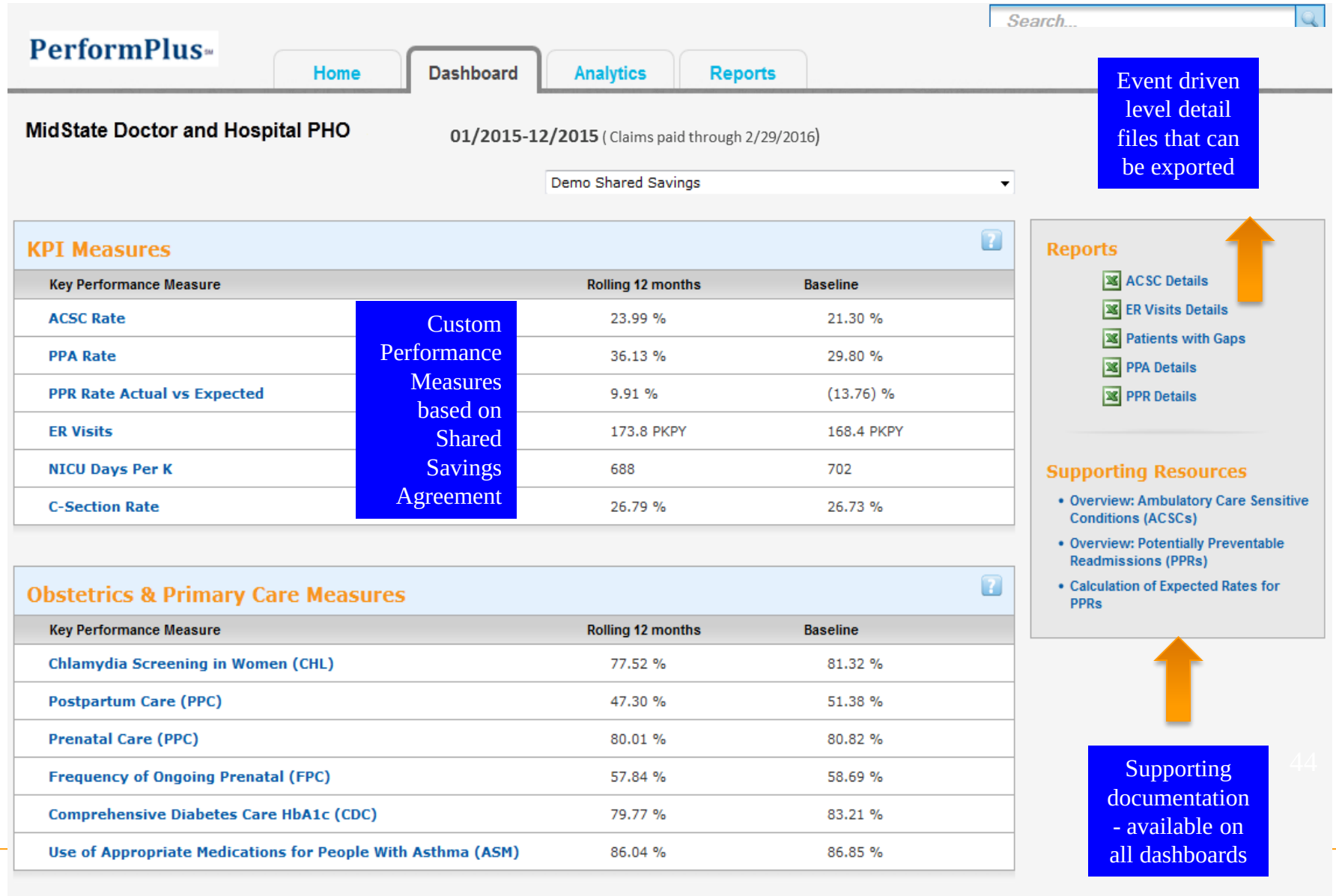
Streamlining Data through the PerformPlus Dashboard



Through our customizable dashboards, AmeriHealth Caritas can quickly develop analyses for internal and external distribution as well as rapidly respond to the changing landscape of value-based purchasing to share detailed and refined data.

> Jefferson has been a value-based partner with AmeriHealth for several years. Having access to the PerformPlus dashboard will be a key driver to our success in AmeriHealth's value-based program. We are able to quickly assess if metrics are within the desired range and generate our own reports to identify improvement opportunities. We rely on the dashboard to help us achieve our targeted goals within the program.
>
> **DEBRA TAYLOR**
> VICE PRESIDENT, PAYER RELATIONS AND CONTRACTING, JEFFERSON HEALTH

PerformPlus® Dashboards – Shared Savings

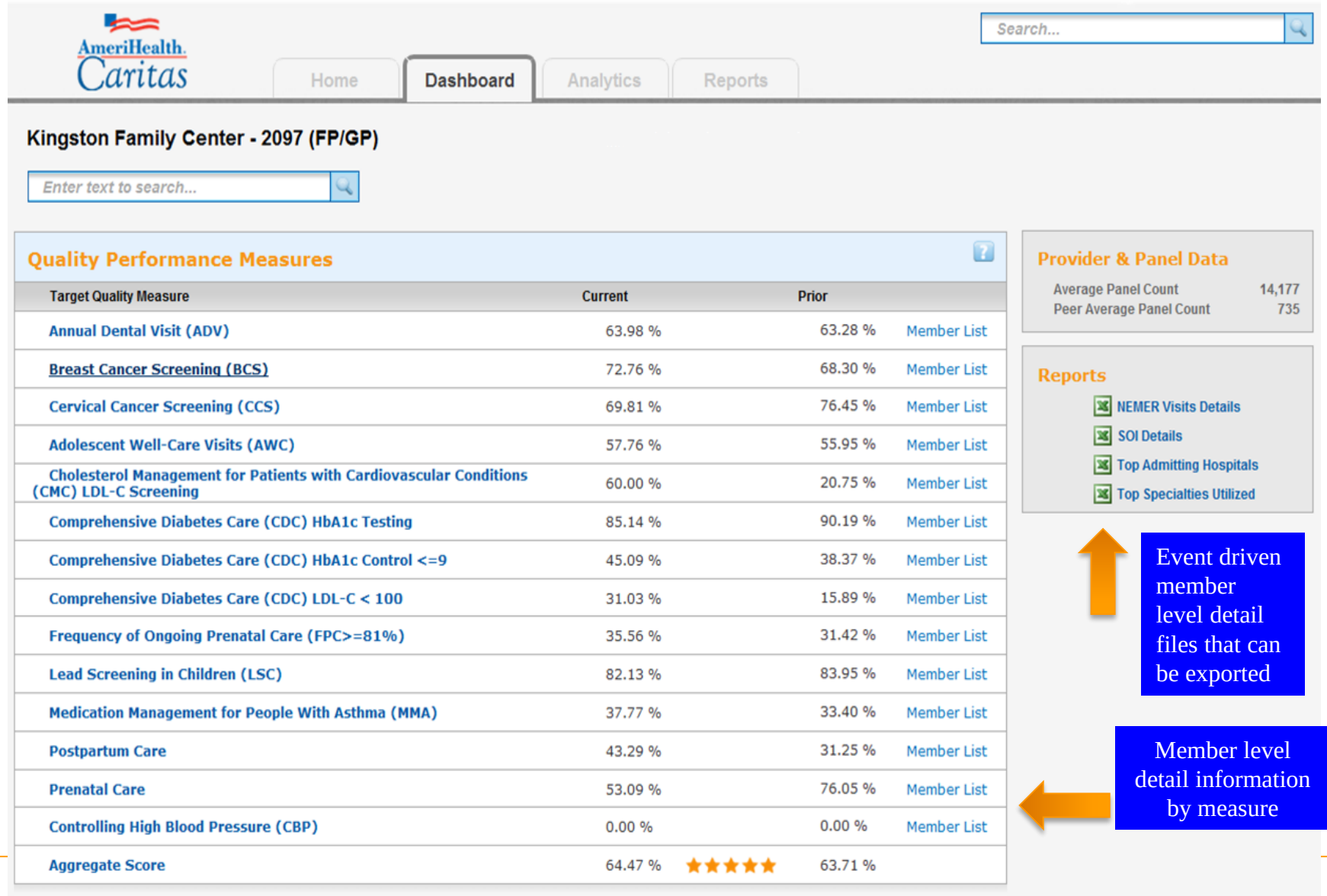


Event driven level detail files that can be exported

Custom Performance Measures based on Shared Savings Agreement

Supporting documentation - available on all dashboards

PerformPlus® Dashboards



Increasing access to data and reports

878 External users

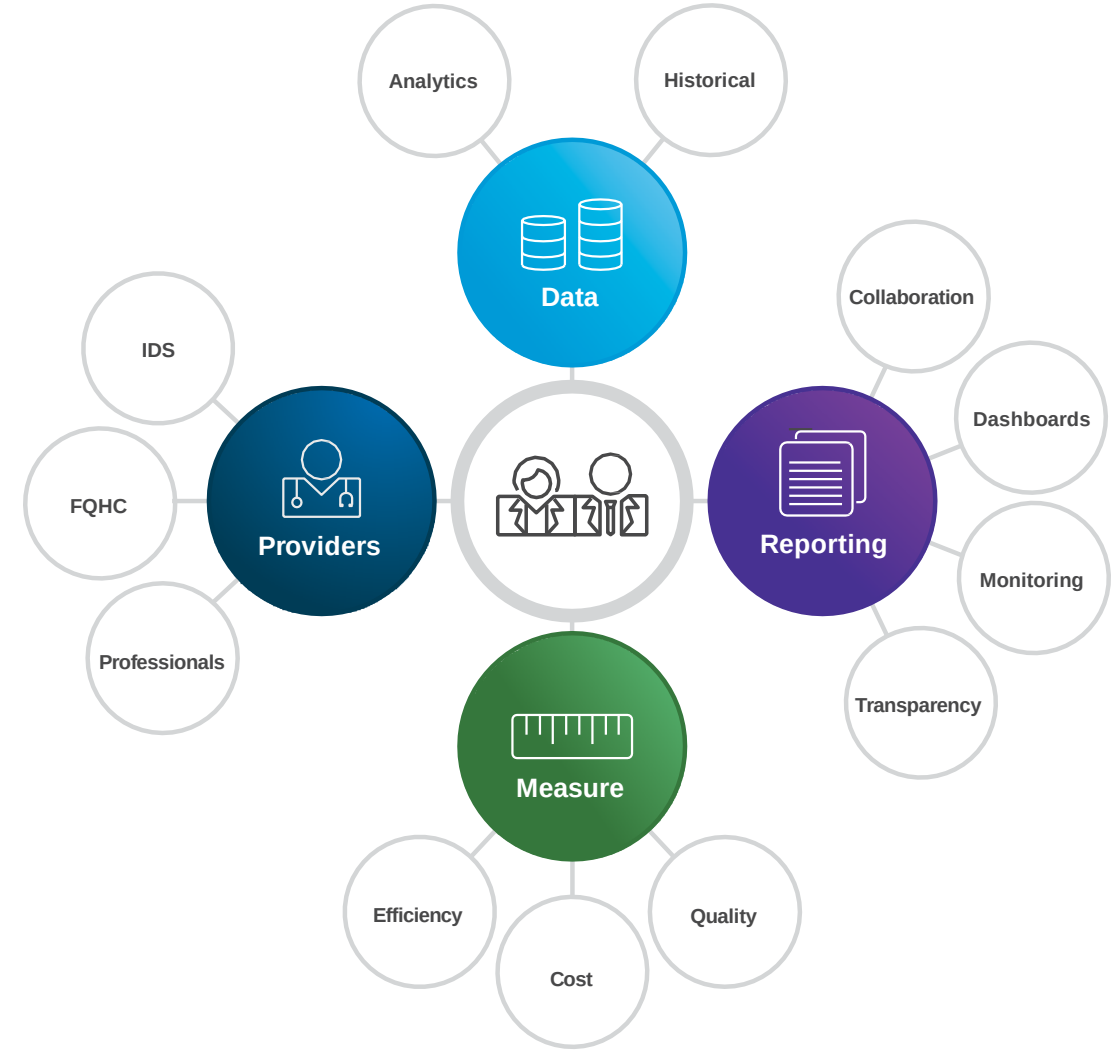
283 Unique provider groups

50% Deployed essential data and reports for over 50% of membership for quality and cost tracking and transparency

> “The Community Partners Program provides us with current, user-friendly data that is easy to access and download. While the program offers a complete incentive, it also provides the tools to do focused patient care management.”
>
> **MARCELLA LINGHAM, ED. D.**
> EXECUTIVE DIRECTOR,
> QUALITY COMMUNITY HEALTH CARE

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.



PerformPlus® Value Based Programs (Examples)

AmeriHealth Caritas
Care is the heart of our work

Community Partners Program (FQHCs)
- Quality
  - HEDIS
- Cost/Efficiency
  - Potentially Preventable Readmissions
  - Potentially Preventable Admission Rate
  - Potentially Preventable ER Visit Rate
- Administrative Bonus
  - PCMH Status

Integrated Behavioral Health
- Efficiency measures including potentially preventable ER utilization
- Behavioral Health quality measures:
  - Adherence to Antipsychotic Medications for individuals with Schizophrenia
  - Antidepressant Medication Management (AMM)
  - Follow-Up After Hospitalization for Mental Illness (FUH)

Full Risk Model
- Quality based guardrails governing risk allocation/sharing.
- MLR/Percent of Premium/Total Cost of Care
- Outcomes capped at upside and downside corridors

Open Arms for IDD, SNF, Home Health
- Quality
- Cost/Efficiency
  - Potentially Preventable Readmissions
  - Potentially Preventable Admission Rate
  - Potentially Preventable ER Visit Rate
- Administrative Bonus
  - Rewards for care coordination and information exchange
  - Rewards for offering a broad array of services

Partial Risk Model
- Continually enrolled population identified by specific risk stratification
- Excludes non users, maternity members and those with malignancies and catastrophic health conditions
- Outcomes capped at upside and downside corridors

Quality Enhancement Program (QEP) - PCPs
- Quality
  - HEDIS
  - PCMH Status
- Efficiency
  - Cost Efficiency
  - Non-Emergent ER Utilization
  - Improvement Incentive
  - Preventable Readmissions
  - Total Cost of Care

Shared Savings Program

Quality
- HEDIS
- Hospital Safety Measures
- Transitions in care

Cost/Efficiency
- Potentially Preventable Readmissions
- Potentially Preventable Admission Rate
- Potentially Preventable ER Visit Rate
- NICU LOS

Woman's Health Program
- Quality
  - HEDIS
  - NQF
- Efficiency/Transparency
  - NICU Rates
  - ONAF forms
- Participation Standards & Administrative
  - Program participation standards
  - Performance on Access to Care Survey/
  - Complaints & Grievances

PerformPlus® Potential Program Measures

Cost & Efficiency Measures

- ***Potentially Preventable Admissions (PPAs)***
  - PPAs are admissions to a hospital or long-term care facility that could reasonably be prevented if care and treatment were provided according to accepted standards of care.
- **Potentially Preventable Emergency Visits (PPVs)**
  - PPVs are emergency department visits for conditions that could otherwise be treated by a care provider in a non-emergency setting.
- **Potentially Preventable Readmissions (PPRs)**
  - PPRs are return hospitalizations that may result from deficiencies in care or treatment provided during a previous hospital stay.

Quality Measures

- Includes mutually agreed upon measures for Behavioral and Physical Health
- Sources: NCQA, CMS, Care Coordination Data and Personal Outcome Measures

Care Coordination Service and Support

- Rewards provided for care coordination, service and information exchange.
- Additional recognition provided for offering or directing a broad array of services, e.g., transportation, home modifications, recreation and work support.

AmeriHealth Caritas
Practice Transformation &
Provider Partnership Overview

Practice Transformation Program

Our multidisciplinary Practice Transformation team provides expert support and educational resources, including:

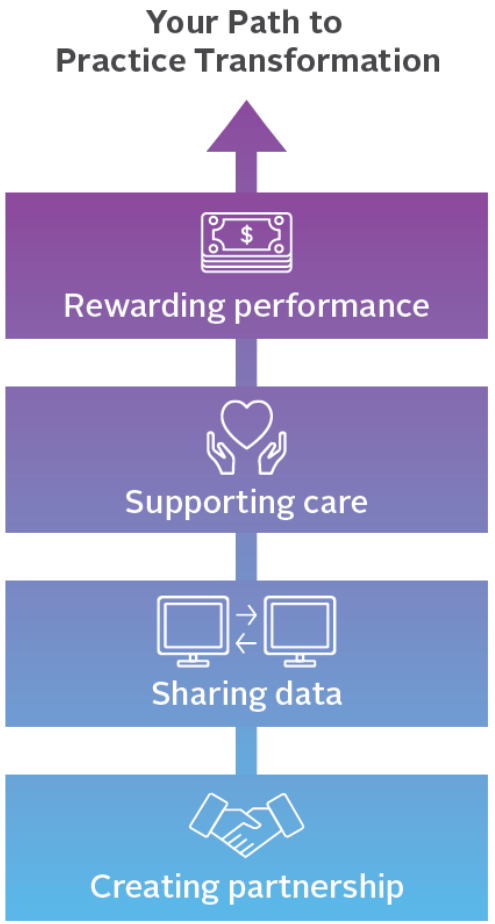
- On-site practice transformation coaches with expertise in quality improvement, population management, service coordination, and data analysis to support transformation.
- Resources for implementing behavioral integration and medication management strategies, such as for opioid use, where appropriate.
- Tools for rapid-cycle improvement and patient registries for identifying gaps in care and tracking outcomes.
- Proactive, data-driven identification of members likely to benefit from targeted training.
- Interventions to help empower members to participate in improving their own health.

Practice Transformation Program

Through collaboration, we can:

- Assess and identify practice improvement opportunities.
- Help you optimize access to and use of member clinical data.
- Provide on-site coaching on the effective use of actionable data and hands-on workflow support.
- Develop, implement, monitor, and track improvement activities.
- Identify and cross-pollinate best practices.
- Coordinate resources to address practice's individualized needs.

The Practice Transformation Director works in partnership with your dedicated Account Executive, providing additional support that focuses on targeted clinical practice performance improvement and practice transformation.



Provider Partnership Opportunities

- Support for Person-Centered Care.
  - Integrated Care Management.
  - Integrated Behavioral Health Care.
  - Community Outreach Teams.
  - Community Connectors.
- Value-Based Programs for our Provider Partners.
  - Provider Dashboards.
  - Robust Analytics and Data Sharing.
  - Resource/Support for Success.
- HEDIS Performance, Challenges, and Strategies for improvement.

More than

35 YEARS

of making

care the **heart**

of our **work.**

AmeriHealth Caritas

Care is the heart of our work

Summary, Questions and Discussion

DON'T FORGET – HIE CONNECTIVITY FOR PROVIDERS BY JUNE 1, 2019