Value-Based Purchasing: Key Components to Balancing Care and Cost

Jason Barkey, MPA, Director of Quality Improvement
St. Joseph Orphanage Cincinnati, Ohio

Marcia Guida James, MS, MBA, MS-HP, CPC
National Director, Value Based Solutions
Aetna Medicaid

David R. Swann, MA, LCAS, CCS, LPC, NCC
Senior Healthcare Integration Consultant
MTM Services

Critical Balance for Value and Cost Using Performance Measures

- Performance measures must include both processes and outcomes

- Is better quality of care provided and demonstrated to achieve the value OR is care being limited in a short plan to achieve cost savings

- Payers will use "Advanced" payment strategies such as paying for value and providers will need to match these strategies with "Advanced" measures of results and outcomes.

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New Levels of Accountability for Providers and Managed Care To Balance Care and Cost

- Accountability for a population (public health model). E.g. the greatest risk for a Administrative Organization are the enrollees that are <u>not engaged</u> in treatment.

- Renewed focus on Better Care – quality of care rather than quality of services

- Financial risk sharing to achieve outcomes, lowering the overall cost of care.

- Providers are going to have to deliver outcome-based care and manage inside alternative payment models that <u>are not</u> fee-for-service but value-based strategies (pay for impact).

- These are "Game Changers"

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Provider Readiness For Managed Care – Business and Clinical Transformation

- Accountability is a central theme of healthcare reform- accountability and stewards of healthcare resources

- Pressure to
  - Be effective – Metrics and outcomes
  - Be efficient – Is your cost of care competitive?
  - Adapt to changing revenue methods – emphasis on community-based early delivery of care as more restrictive, higher-cost care, is reduced.

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Requires Outcomes/Results Demonstration
Sample Process and Results Leading to Higher Value

- Reducing clinician variance and variation

- Access to rapid care without delay – when the consumer wants/needs it

- Measuring functional improvement and symptom change and reporting – measuring treatment response

- Reducing high cost utilization – e.g. hospital, ED, and Residential Care

- Reducing cost of care components and total cost of care

- Improving consumer experience of care

- Improving health outcomes

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Quality and Costs: Do We Know Both?

Our Costing Methodology Defined —

Total Cost for Service Delivery
- Direct Service Staff Salary
- Direct Service Staff Fringe Benefits
- Non-Direct Costs (All other costs)

Total Revenue for Service Delivery
- Net Reimbursement actually Attained/ Deposited. *(This takes into account Denial Rate, Self Pay, Sliding Fee Scale, etc.)*

– Divided By –

Total Billable Direct Service Hours Delivered **
- All Direct Service Hours Delivered by Direct Service Staff that are eligible to be billed via a CPT Code or against a Grant.

** Utilizing the common denominator of total Billable Direct Service Hours instead of total hours worked per year assures an apples to apples comparison of an organization's true cost versus revenue per direct service hour.

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Managed Behavioral Health Concerns

- Inappropriate and/or overutilization of certain services (superutilizers)

- High cost services

- Fast access to lower cost services for members

- Better practices leading to improved care

- Coordinated care leads to decreased costs

- Determining the value of care

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Provider Concerns – Social Determinants of Health in Value-Based Care

- Evidence continues to mount about the ability of Social Determinants of Health interventions to improve outcomes and lower costs, particularly concerning the role of health care organizations.
  - Meeting daily needs such as housing and food
  - Access to education and job opportunities
  - Job training
  - Access to health care services
  - Community-based resources in support of community living
  - Transportation

- Costs of care including social determinants are believed to cost more.

- Use of data-driven information to communicate the proper level of care – e.g. ICD-10 use of the "Z" codes reported to the health plan would be the Social Determinant of Health indicator. Are proper diagnoses currently being provided?

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Transformation Processes Needed

1. Utilization of services – volume to value and escaping the more we do the more we are paid

2. Focus on measured results and reduced cost

3. Reduce unrealized service capacity that increases your cost and reduces your results – managing utilization

4. Transformed treatment approaches producing results (e.g. focus on engagement, treat to target, modification of treatment plans according to client's progress, etc.)

5. Data management capabilities to drive results

6. Effective and low cost documentation, back office functions (claims, service and diagnosis codes, processes)

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Service Utilization: Results Driven

- Are People Receiving the……
  - Right/best service
  - Right Time
  - Right Intensity/frequency
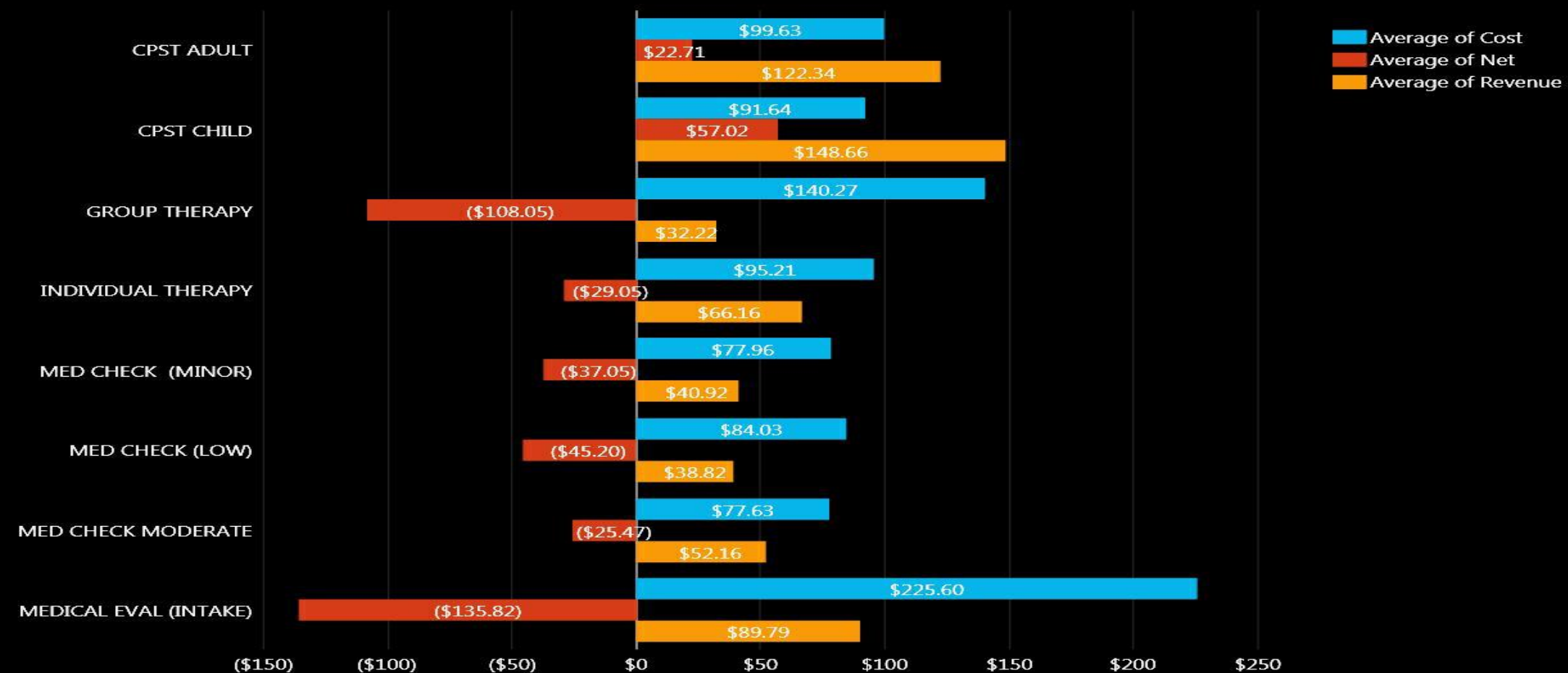 - Right Cost

  Are Providers Delivering…..
  - Maximum value with amount of care benchmarked against standards – clinical practice guidelines
  - Achieving the best outcomes at the lowest cost
  - Move from a supply-driven health care system organized around what clinicians do and toward a consumer-centered system organized around what consumers need

  - Know what data is sent to payers through claims-e.g. sending the same ICD-10 Dx code without modification as the consumer improves tells payer consumer has not responded to treatment.

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Sample Data Sets Demonstrating Cost and Value

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Convene. Strategize. Activate.

Know Your Costs and Know Your Value

2Da. Product Line Average Costs and Revenues

Know Your Costs and Know Your Outcomes

2d. Functional Outcomes and Service Density

| 3528 Persons | 5.5 ServiceDensity | -0.15 DeltaScore | $2,237,558.37 Revenue | $2,244,855.25 Cost | ($7,296.88) Net | 1 OrgDispersion |
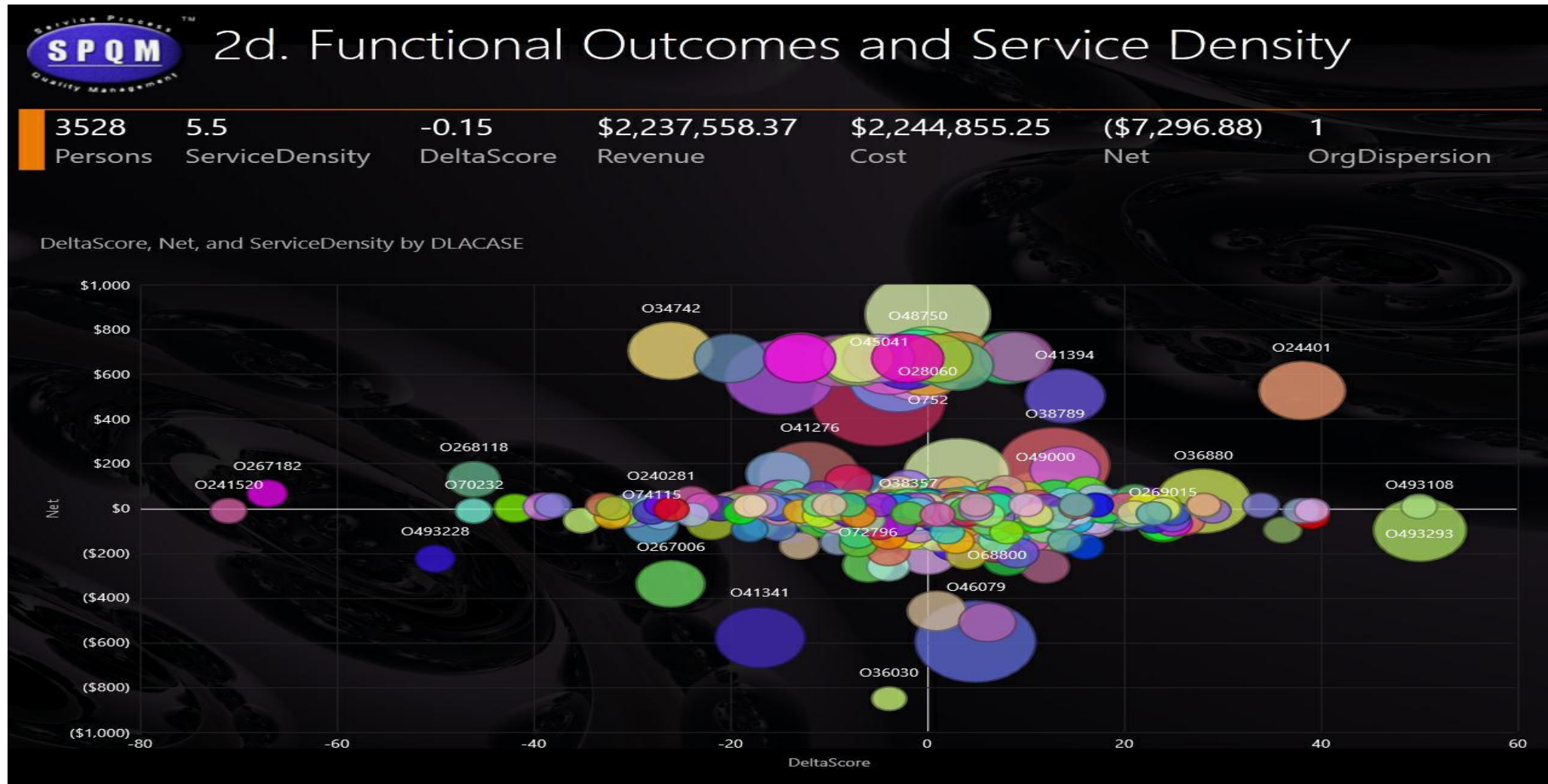
2g. Feature Analysis: Diagnosis

| 44707 | 11.2 | 0.23 | $28,350,246.79 | $32,218,357.96 | ($3,868,111.17) | 16 |
| Persons | ServiceDensity | DeltaScore | Revenue | Cost | Net | OrgDispersion |

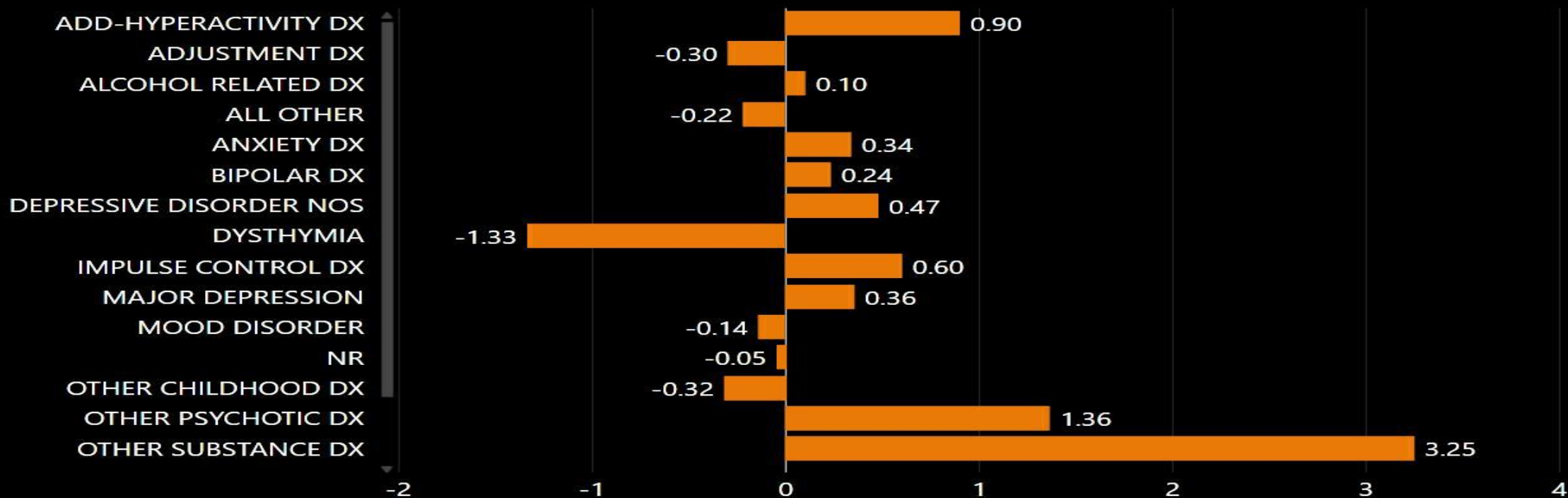DeltaScore, Net, and ServiceDensity by Diag1AGroup
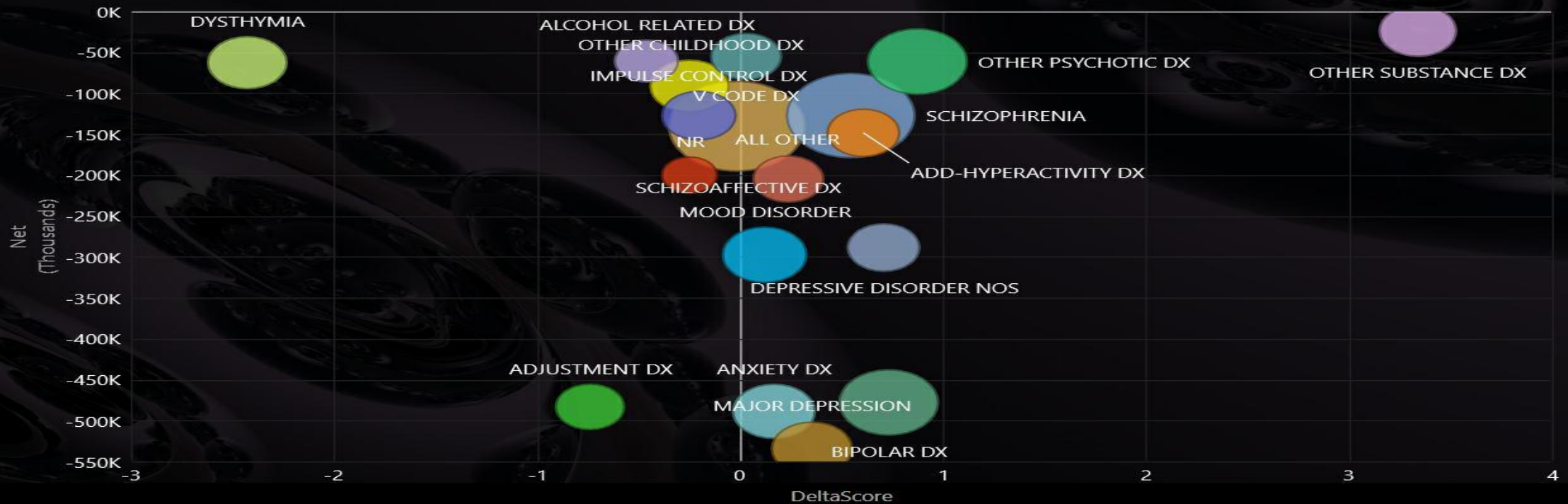
2a. Scaled Outcomes by Diagnostic Group

72562 Persons	**21.4** ServiceDensity	**0.20** DeltaScore	**$85,684,820.14** Revenue	**$97,531,912.20** Cost	**($11,847,092.06)** Net	**16** OrgDispersion

DeltaScore by Diag1AGroup

Diag1AGroup	DeltaScore
ADD-HYPERACTIVITY DX	0.90
ADJUSTMENT DX	-0.30
ALCOHOL RELATED DX	0.10
ALL OTHER	-0.22
ANXIETY DX	0.34
BIPOLAR DX	0.24
DEPRESSIVE DISORDER NOS	0.47
DYSTHYMIA	-1.33
IMPULSE CONTROL DX	0.60
MAJOR DEPRESSION	0.36
MOOD DISORDER	-0.14
NR	-0.05
OTHER CHILDHOOD DX	-0.32
OTHER PSYCHOTIC DX	1.36
OTHER SUBSTANCE DX	3.25

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A Health Plan's Role in Change to Value Based Care

Aetna Better Health

Health Plan's Role in Transition to Value Based Care

- Health Plans MUST have a real understanding of provider challenges
  - ✓ Location
  - ✓ Size matters, capabilities dependent on size
  - ✓ What tools do providers need? Data, analytics, infrastructure, or stand aside?
- Approach must be bottom up vs. top down
  - ✓ Do not dictate
  - ✓ Inflexibility is off –putting

Provider's Role in Transition to Value Based Care

- Providers should also understand how to relate to the Managed Care Organization

  - ✓ How does the provider relate to the MCO?
    - Business mode: Email, Phone calls, webex
    - Relationship perspective: Skeptical, collaborative, trusting, wary
  - ✓ What is best way for provider to interact w/the MCO?
    - In person?
    - Meet provider where they are metaphorically?
  - ✓ Understanding the financial impact for both the provider and the MCO
    - High dollars creates the impact

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What does SUCCESS look like?

✓Successful provider attributes
- Engaged
- Interested
- Willing to ask questions

What does Value Based experience look like?

- ✓ Most value based experiences begin with either Pay for Reporting/Pay for Quality/Pay for Performance
  - Do you see the most frequent occurrence in VB—what does Value based look like? Episode based or—what is aetna's most used practices in VB? P4Q ? Episodes?
- ✓ Metrics and targets
  - Utilization metrics: ED/1000, Readmission rates
  - Quality metrics: well child care, screenings, Follow up after behavioral health admission
- Funding depressive episode treatments

What does the future of the Value Based experience look like?

✓ Funding episodes for depressive treatments
  - Requires claim system upgrades?
  - Manual processing of episodes

✓ More shared savings type agreements
  - Self funded/budget neutral

✓ More technology based in foundation

How a Not-For-Profit Provider Prepares for Success

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Payment Innovation Overview

- Across all 50 states, Ohio has the 18th highest healthcare spend per person, but ranks 36th in terms of population health outcomes
- A fee for service world perpetuates more volume, more fragmentation, more variation and no assurance of quality
- In 2013, Ohio Department of Medicaid (ODM) received a 5 year Federal Grant to design payment models that increase access to care and support payment innovation
- ODM Goal: 80-90 percent of Ohio's Medicaid population is in some value-based payment model (combination of episodes-and population-based payment) within five years
- Episode Based Payment model launched in 2014 with 6 physical health care episodes, followed with an additional 20 more episodes in 2015
- Twenty more episodes were launched in 2017, including ADHD and ODD
- ODM Goal: 50 more episodes will be launched in the next two years
- Triple Aim: Improved care quality and clinical outcomes and lower costs
- By 2020, all Medicaid managed care plans must link 50% of provider payment to value

ADHD & ODD in Ohio by the Numbers

- In Ohio, the % of youth diagnosed with ADHD increased from 8.9% in 2003 to 14.2% in 2011

- Between October 2014 and September 2015 there were over 70,000 ADHD episodes for Medicaid beneficiaries age 4-20

- These episodes represented over $130 million in Medicaid spend

- Some studies show that 20% of school children are affected by ODD

- Between October 2014 and September 2015 there were over 11,000 ODD episodes for Medicaid beneficiaries age 4-20

- These episodes represented over $27 million in Medicaid spend
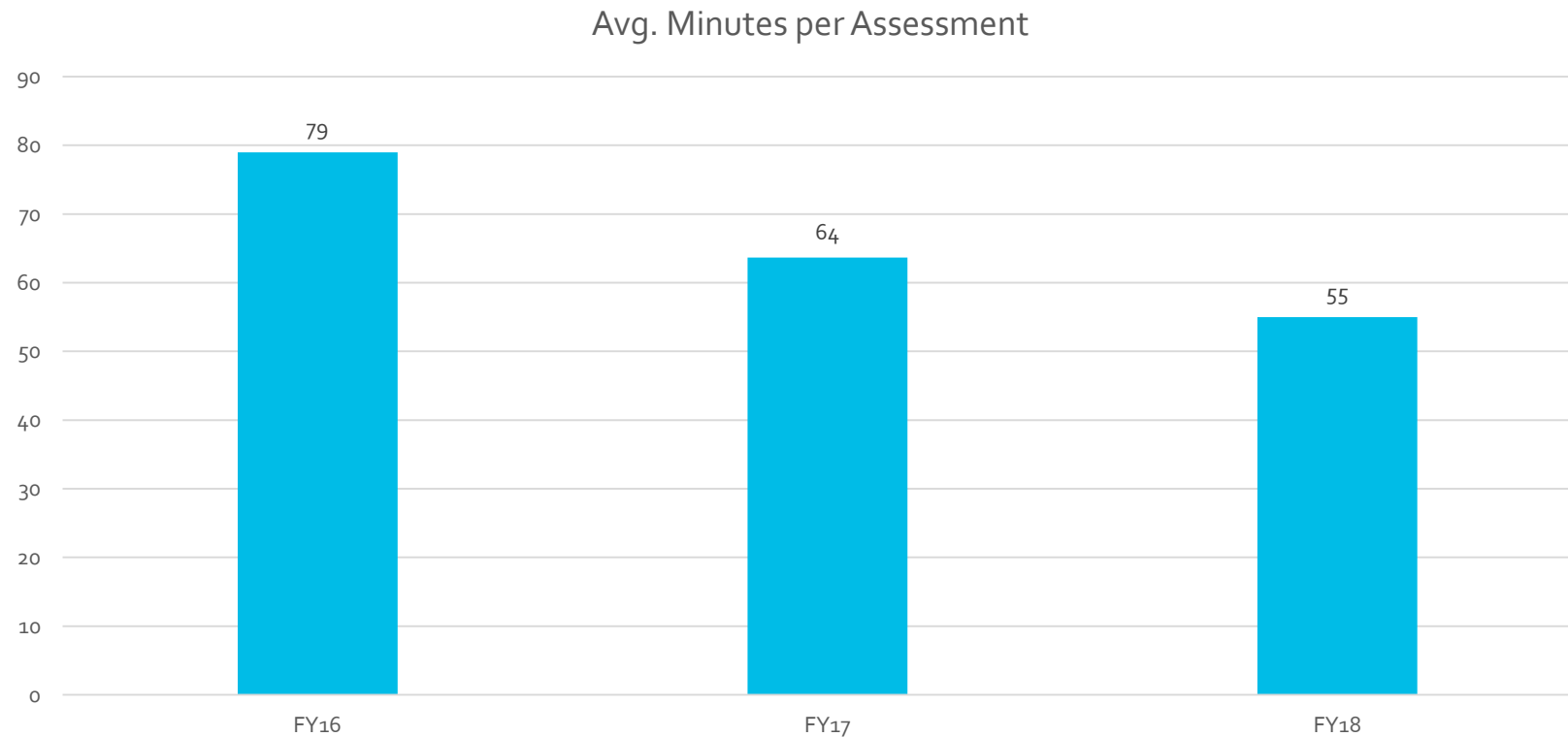
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Changes in Ohio

- Elevation: Financing of Medicaid behavioral health services moved from county administrators to the state-- completed July 2012

- Expansion: Ohio implemented Medicaid expansion to extend Medicaid coverage to more low-income Ohioans, including 500,000 residents with behavioral health needs– completed January 2014

- Modernization: ODM and OhioMHAS have updated code sets to align with national correct health care coding standards– completed January 2018

- Integration: Behavioral health benefits will be "carved in" to Medicaid Managed Care– completed July 2018

Preparations

- The changes proposed by the state were both a burden and an opportunity for SJO
  - Motivated to be the premier behavioral health organization in the Greater Cincinnati area
  - Invested in preparations such as growth in Quality and Billing departments to provide infrastructure needed
  - Worked with trade organizations (The Ohio Council and OACCA) to stay informed and advocate for our needs and preferences
  - Reframed priorities such as engagement, utilization, and use of data to better position ourselves
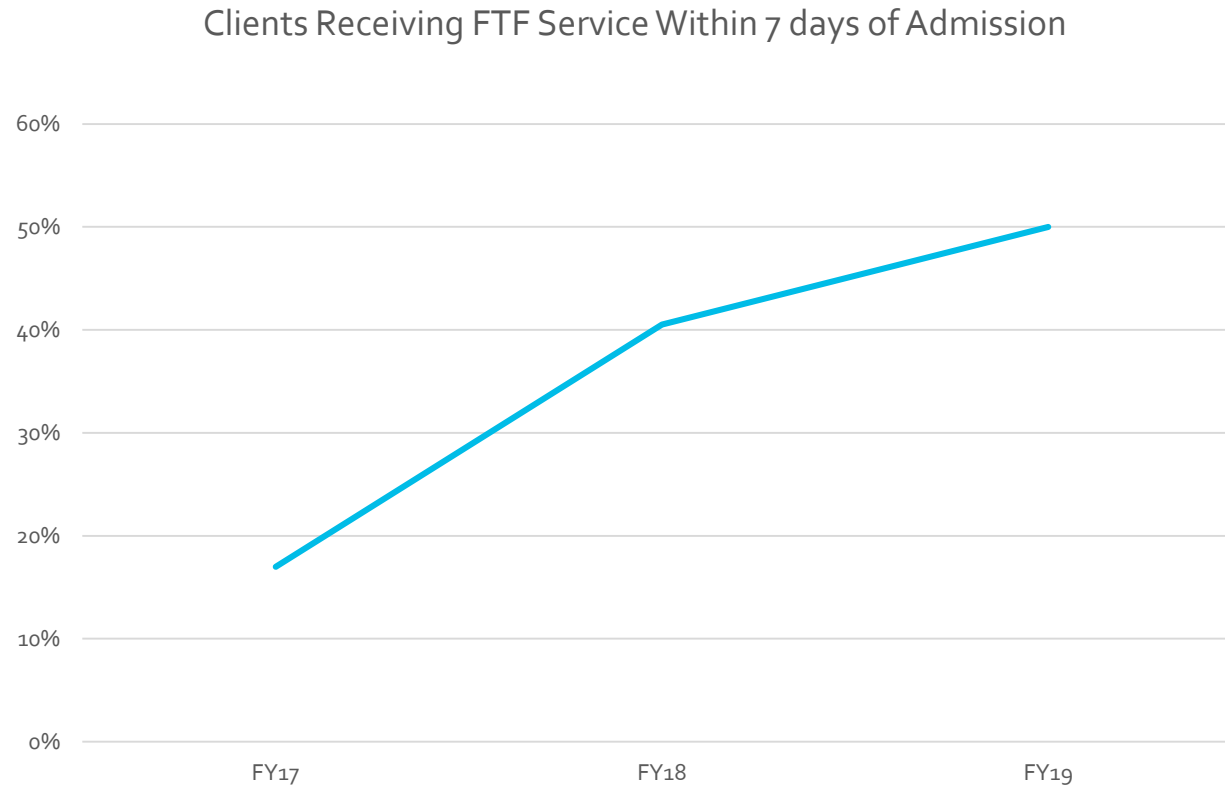
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Using Data

- Increasing clients served required shorter admission appointments

Avg. Minutes per Assessment

	FY16	FY17	FY18
Value	79	64	55

Using Data

- After admission, engagement became a key focus

Clients Receiving FTF Service Within 7 days of Admission

Using Data

- SJO implemented a Level of Care tool to manage risk and better understand our population

LOC Distribution
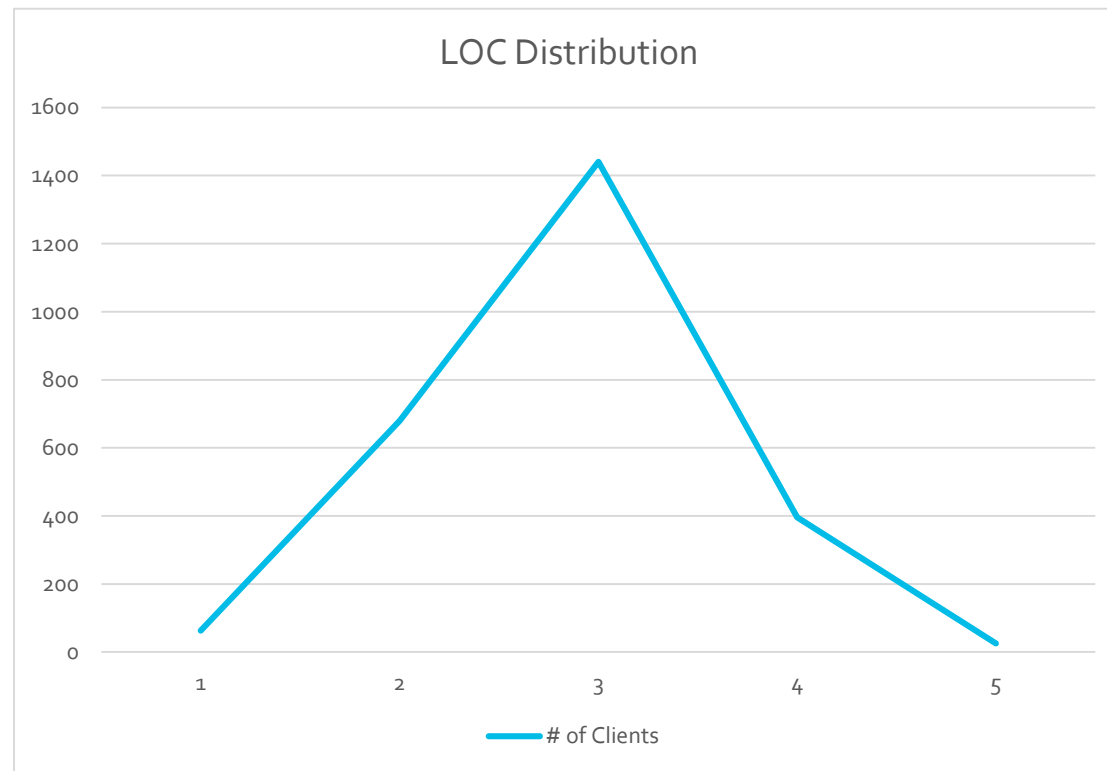
Using Data

- Understanding the value of demonstrating positive outcomes

Clients Demonstrating Improvement on DLA-20
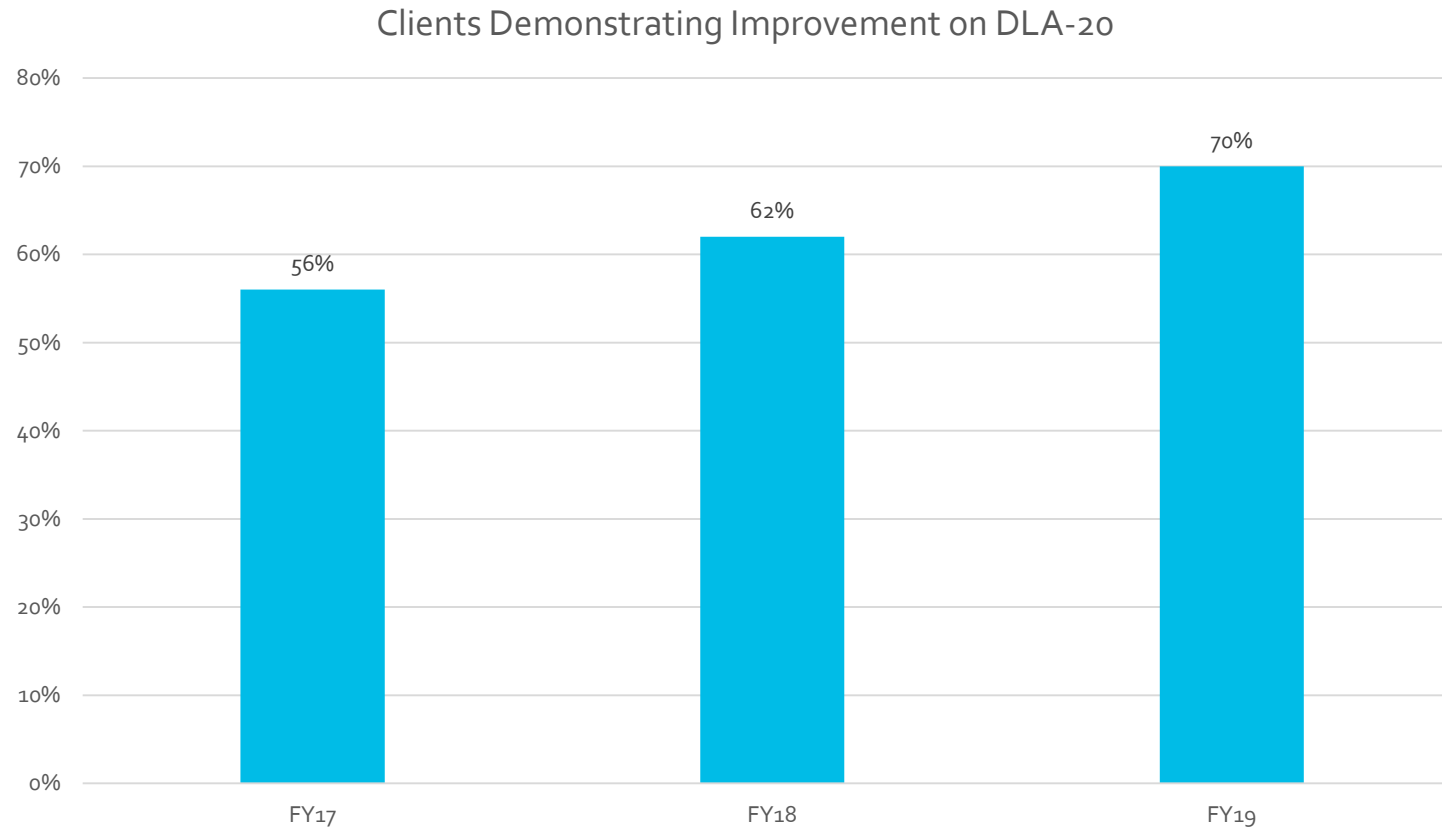
Using Data

- Increasing capacity to meet the community's needs

Number of Clients Served

	FY16	FY17	FY18
	2529	3743	4580

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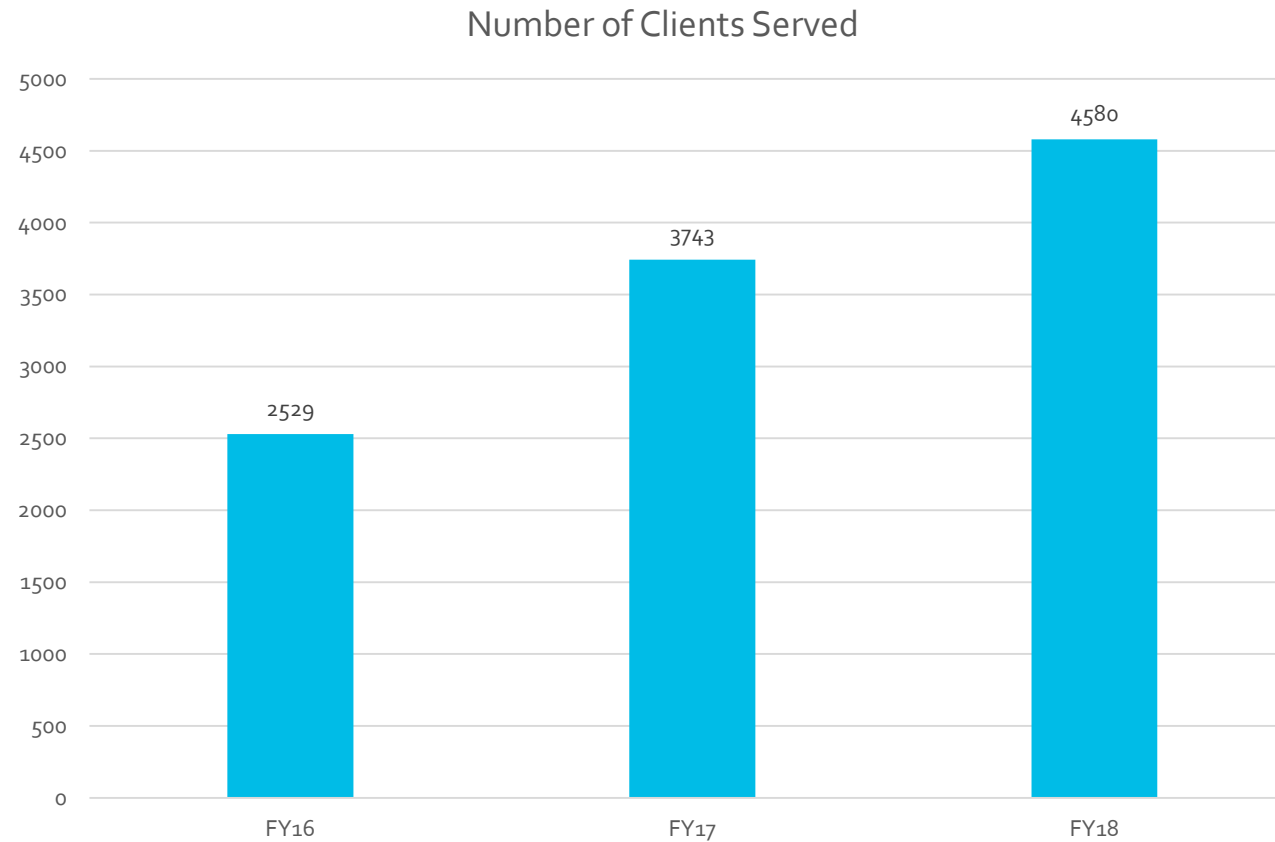
Using Data

- Identifying our costs per unit for each service

Residential and MMC Cost per Unit

Legend:
- Residential Cost per unit
- Residential Billed per unit
- MMC Cost Per Unit
- MMC Billed Per Unit

X-axis: 1st half 17, 2nd half 17, 1st half 18, 2nd half 18, 1st half 19

Y-axis: $50.00 – $450.00
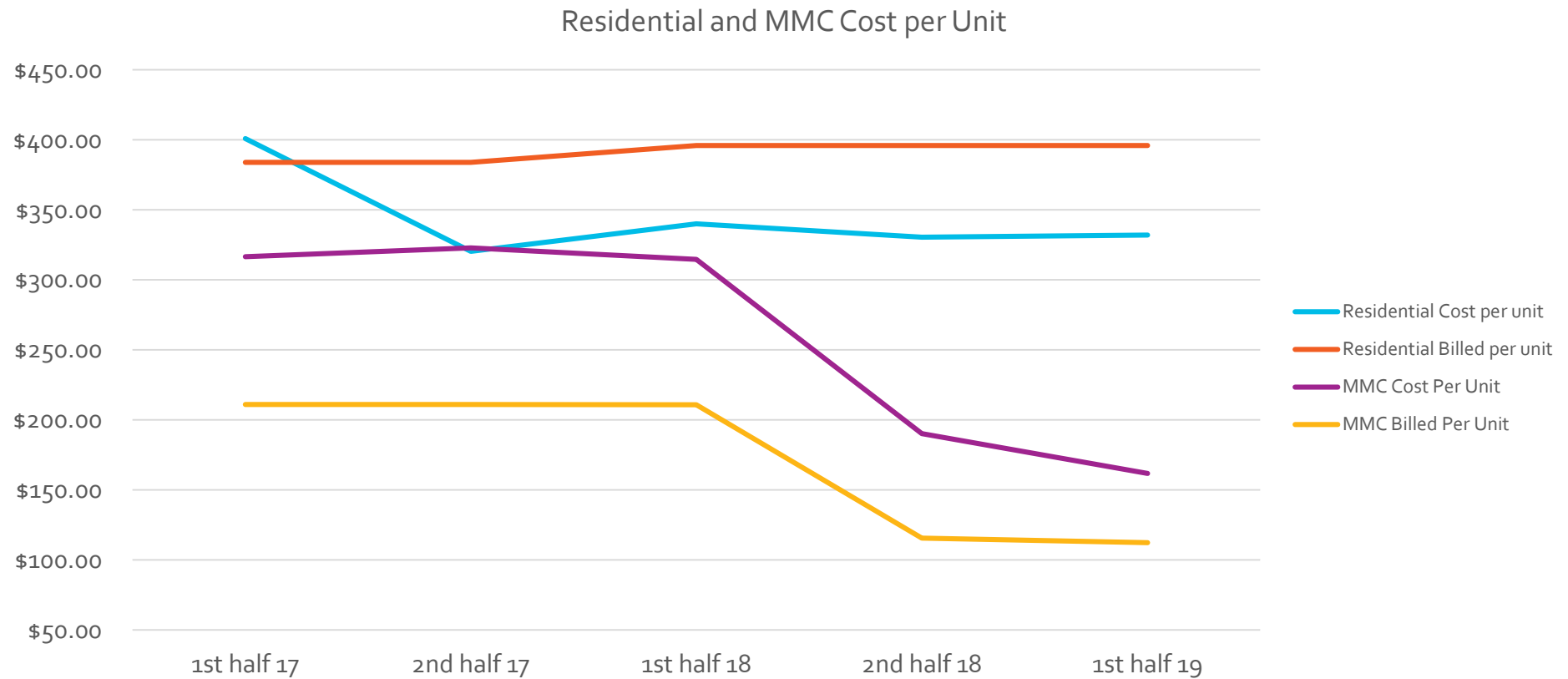
Using Data

- Implemented Quarterly Quality Meetings for each line of service

Quarterly Quality Report

Customer Service	FY16	FY17	Q1	Q2	Q3	Q4	FY18	2018 Target
Respondents recommend services to family and colleagues	N/A	62 NPS	N/A	44 NPS	44 NPS	23 NPS	37 NPS	65 NPS
Respondents will report being satisfied with the quality of services	N/A	84%	N/A	78%	100%	100%	93%	90%
Respondents report satisfaction with level of communication with program staff	N/A	84%	N/A	66%	100%	100%	89%	90%
Best Practices	**FY16**	**FY17**	**Q1**	**Q2**	**Q3**	**Q4**	**FY18**	**2018 Target**
Active clients will have a completed DLA-20 assessment for the quarter	N/A	59%	91%	96%	100%	97%	96%	100%
Clients will show an overall improvement on their DLA-20 score.	N/A	21%	43%	36%	65%	70%	54%	33%
Clients will move to a treat-to-target ISP	N/A	N/A	N/A	N/A	N/A	100%	100%	100%
Clients will be making progress towards or have completed their High School/GED/College/Trade/Empl	N/A	54%	69%	77%	71%	61%	70%	55%
Clients have been employed for 6 weeks	N/A	63%	63%	92%	46%	61%	66%	70%
Clients have not accrued new charges	N/A	69%	88%	94%	89%	89%	90%	75%
Client will maintain placement	N/A	60%	63%	83%	57%	83%	72%	65%
Clients have not been hospitalized	N/A	77%	84%	94%	100%	95%	93%	85%
Safe Environment	**FY16**	**FY17**	**Q1**	**Q2**	**Q3**	**Q4**	**FY18**	**2018 Target**
Program staff will report feeling safe	N/A	100%	67%	100%	100%	N/A	89%	100%
Clients report feeling safe	N/A	100%	100%	100%	100%	100%	100%	100%
Engaged Staff	**FY16**	**FY17**	**Q1**	**Q2**	**Q3**	**Q4**	**FY18**	**2018 Target**
Staff will report being satisfied	N/A	100%	67%	100%	100%	N/A	89%	100%
Turnover is minimized	N/A	43%	0%	0%	14%	14%	7%	50%
Financial Performance	**FY16**	**FY17**	**Q1**	**Q2**	**Q3**	**Q4**	**FY18**	**2018 Target**
Service will maintain financial stability by showing a neutral or positive YTD Net Figure	N/A	Yes	Yes	Yes	Yes	Yes	Yes	Yes

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Hurdles

- Shifting the culture
  - Opportunity to create a new future (190 years old)
  - Quantity to Quality– Pay for performance concepts
  - Documentation shifts
  - Managing to these significant changes

- Educating clinical staff on changes

- Obtaining reliable, valid data from Electronic Health Record

Action Steps

- Moved to a treat to target treatment plan that is shorter and more consumer friendly

- Established a more robust clearing house that also allows front desk and eligibility staff to confirm coverage

- Implemented an in-depth documentation training for newly hired staff to reduce the risk of payback to the Agency while providing the staff member with the skills to document thoroughly and efficiently

- Redefined and modernized many back office processes including co-pay collection, customer service, timely billing and aggressive follow up on denied claims

- Provided training to staff on motivational interviewing, collaborative documentation, ICD10 diagnosing, treat to target

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Action Steps

- Implemented central scheduling

- Reduced assessment times for access appointments

- Reduced all appointment times overall including pharm mgmt, therapy, and case management

- Implemented 4 question satisfaction survey to be taken at the end of appointments to continuously monitor for process improvement activities

- Implemented engagement specialist

- Implement a Level of Care tool and manage utilization accordingly

- Geo-mapped staff for case assignments to increase efficiency

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Ready…Set…Go

- Questions
- Comments
- Discussion

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