



HCBS BUSINESS ACUMEN CENTER

BUSINESS DEVELOPMENT LEARNING COLLABORATIVE

HCBS Conference
August 26-29, 2019

Welcome & Introductions



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- Erica Lindquist, Senior Director of Business Acumen
 - ▣ National Association of States United for Aging and Disabilities (NASUAD)

- Donna Martin, Director for State Partnerships & Special Projects
 - ▣ American Network of Community Options and Resources (ANCOR)

Today's Agenda

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- ACL Updates
- State Team Updates and Presentations
- State Team Challenge
- Value Propositions
- Pitch to the Payers
- Value Based Reimbursement
- Wrap-Up/Next Steps
- Dinner @ Fells Point Tavern
 - ▣ 1606 Thames Street



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ACL Update

Joseph Lugo, Administration for Community Living



1 2

Using Margin

to

Drive Mission

ACL Business Acumen

1

Pre-Contract
Activities

2

Contract
Review
(Pricing, Negotiation)

TA
Framework

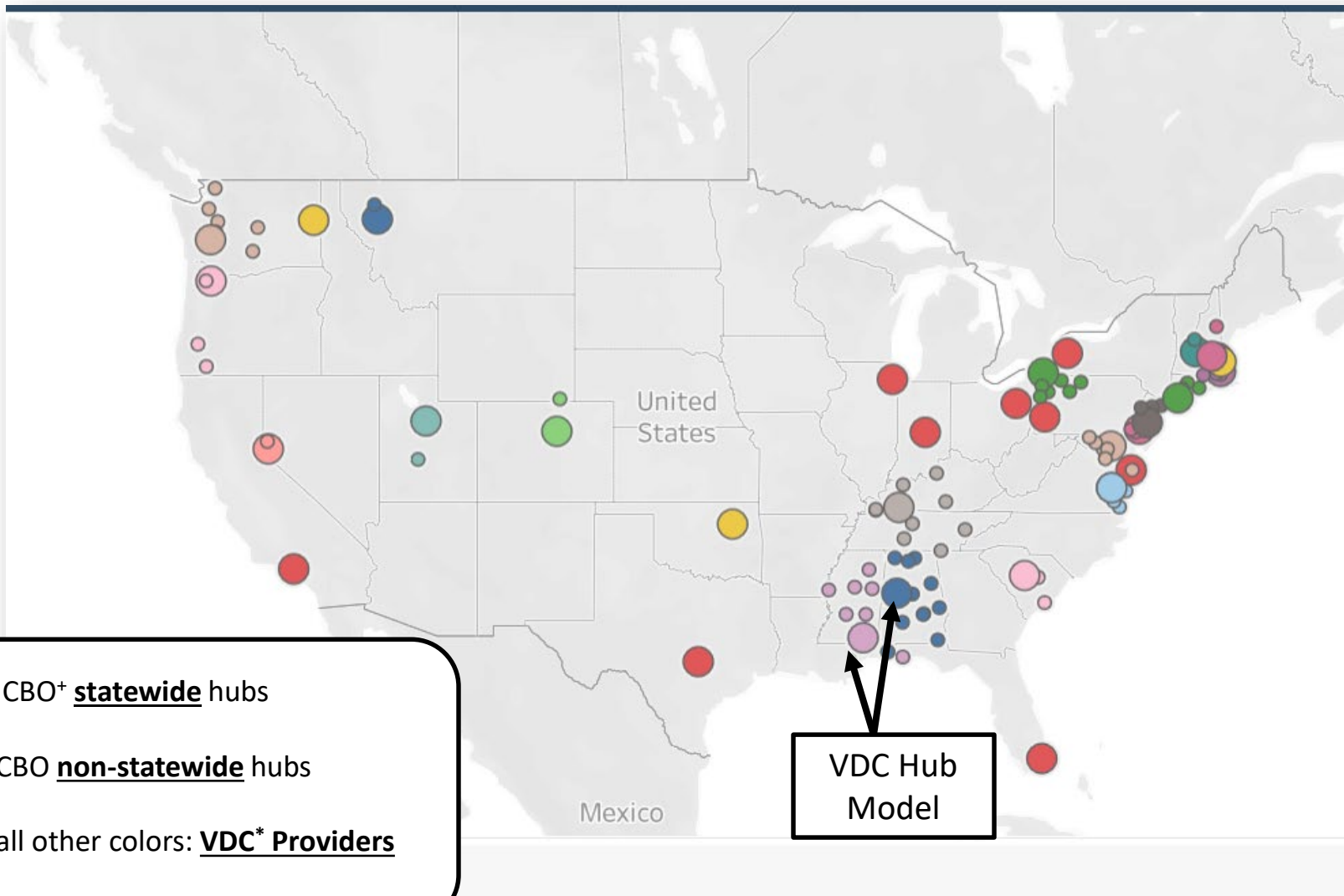
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Pre-
Implementation
Activities
(Post-Contract Award)

4

Contract
Implementation &
Monitoring
*(Continuous Quality
Improvement)*

National Network Development



+ CBO = Community Based Organization

* VDC = Veteran Directed Care Program

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State Team Challenge

State Team Challenge

■ Normal report-out method, with a twist

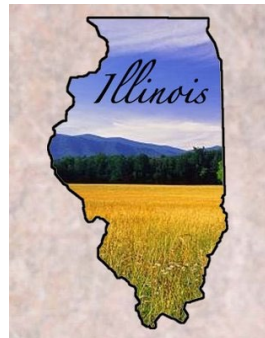
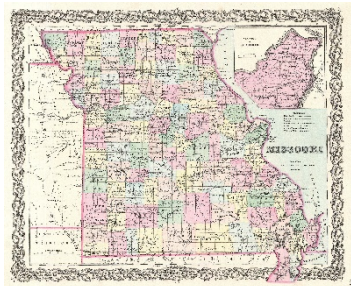
■ Draw team names from a hat

■ “Listening team” answers at the end:

■ What surprised us or was new information?

■ How does their work/learnings apply to our work?

■ How would you explain their effort to someone who knows nothing about it?



State Team Challenge



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Business Development

- Module 1
- Module 2
- Strategic Opportunities
- Challenges/Barriers to be overcome
- Next Steps

Business Acumen

- Original Objective
- Key Lessons
- Surprises
- Status to Date
- Next Steps

BUSINESS DEVELOPMENT LEARNING COLLABORATIVE

ILLINOIS TEAM UPDATE

KATHY CARMODY, CEO

AUGUST 2019



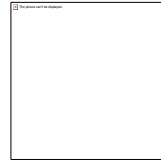
Key Findings

- BDLC activities raised organizational awareness of competencies needed to be successful in an alternate payer system
- Board understanding, buy-in and involvement in preparing organization for future funding models
- BDLC assisted in getting beyond resistance to alternate funding models and opened minds to exploring possibilities for organizational success
- Awareness of key organizational competencies that will be needed which aren't currently in place

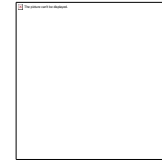
Most Helpful Resources

- SWOT Analysis and Environmental Scan
- Templates and Instructions
- Hearing from other organizations and states
- Manuals with descriptions and tools.

How Are CBOs Positioning Themselves for the Future



Reviewing alternative
funding models used
elsewhere



Converting data collection
tools to ones that will
position us for the future



Cultivating partnerships
and collaboration



Exploring expansion and
acquisition

Strategic Opportunities



Service Diversification



Service Expansion

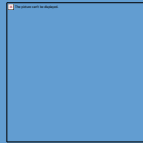


Partnerships with health care providers



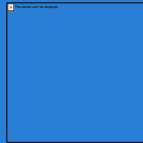
Partnerships with MCOs to share I/DD expertise

Key Challenges Facing Agencies



Critical staff shortages, especially DSP's and Nurses, resulting in:

Declining revenue base from serving fewer people, and inability to grow
Difficulty providing person centered services



Inadequate funding compounded by increase in minimum wage



Lack of direction from the State; rely on outside entities to stay abreast of best practices

Barriers to Completing the Project

- Timeframes
- Aligning BDLC timeframes with agency strategic planning cycle
- Comfort with sharing information with others
- Difficult to align this project with board involvement

Summary

- BDLC tools were helpful; needed more time
- Staff shortages and inadequate funding are root issues driving agency challenges
- These challenges hinder agencies' ability to position themselves for the future
- Agencies are seeking information and tools to prepare for changes to alternative funding models

Virginia Objectives

- Goal/Outcomes Anticipated
 - A strong CBO network
 - A competent CBO network
 - Policies and Practices that support a strong, competent CBO network while allowing for flexibility and innovation

Module 1- Environmental Scan

- A lot of change occurring in Virginia
 - Waiver Redesign
 - Still gaps in services
 - Behavioral Health Redesign
 - Managed Care initiation in BH
 - STEP-VA project
 - Regulatory changes
 - Waiver
 - Licensing

Module 2- SWOT Analysis

- Macro Level
 - Similarities among provider
 - Identified 7 areas that impact all providers
- Micro Level
 - Uniqueness with in providers
 - Promising Best Practices
 - Sharing struggles as important and sharing successes

Opportunities

What Do We Want Our Story To Be

May – June 2019

Harvard Business Revi24ew

Effective training
that provides
instant return on
investment

Record low critical
incidents

increased employee
engagement

*“This training
was amazing.
The new
approach gave
staff the
empathy and
skills to support
Mary more
holistically than
ever before.”*



Digging for Gold



Local Providers Mine Virginia's Past to find the Workforce Treasures of the Future

✓ DBHDS leads alliance between local providers and major institutions (page 3)

✓ Good Neighbor says, *"Our staff have hearts of gold – they see the person, not the disability!"*

✓ Training Nuggets for CBOs (page 12)



DBHDS Quarterly

May 2019

How much documentation is enough?

Providers are asking us:

- ☞ How do we have quality without over regulation?
- ☞ How much time do we spend on paperwork versus time spent on service delivery?
- ☞ Can we better synchronize regulatory reviews?

“We can finally get back to the business of relationships.”

In a recent meeting of Virginia’s business development learning community, community based organizations talked about the challenges of building relationships with clients and their families in the community because their time was spent behind desks documenting charts and plans.



We Heard Your Ideas!!!

Chip Dodd, CEO of Support Services Virginia, told us “I finally can pay my DSPs more for what they do now that we have reduced the need for redundant

oversight.”
IMPROVING LIVES
– REDUCING
PAPER
FOCUSING ON
PEOPLE...NOT
PAPER!

Challenges/Barriers

- Time
 - Dedicating time and resources
- Participation
 - Not a Crisis until it is a Crisis
- Knowledge, Skills and Abilities
 - Right People
 - Right Talents
 - Right Motivation

Next Step

- Develop a Business Development Library
- Incorporate training and modules into our Licensing Prep class
- Continue to finish what we started
 - Leadership Team Meet
 - Strategic Vision
 - PIRW
 - Address issues/barriers
 - State of the State
 - Continue to refine data to tell the story

Original State Team Aim

- What did your team originally propose in terms of your aim / anticipated outcomes?

Promote a long-term services and support system (LTSS) that takes full advantage of the strengths of both community-based organizations (CBOs) and managed care organizations (MCOs) to help people with disabilities transition from institutions to the community.

Original State Team Aim



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Original State Team Aim



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- What did your team originally propose in terms of your aim/anticipated outcomes?
 - create a sustainable relocation process that can efficiently serve people with disabilities seeking to live in the most integrated setting of their choice.
 - CBOs and MCOs will collaborate to facilitate a transition from a cost reimbursement payment system to the most effective contracting and payment system under Medicaid managed care.

State Team Achievements



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- What has our state team achieved, to date?
 - Greater understanding each other's business practice and shared goals.
 - Devoted one meeting to discussing the history, philosophy, goals and activities of each partner entity.
 - Identified common goal of helping individuals with disabilities live in the setting of their choice.
 - Experienced collaborative problem-solving through sub-group work focused on a specific task

State Team Achievements



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■ What has our state team achieved, to date?

- The two entities are working together to revise the current contracts with MCOs.
 - Contracts subgroup (comprised of MCOs and CBOs) obtained pro bono legal assistance to review and recommend changes to future contracts for more consistency, clarity and fairness.
 - CBOs and MCOs collaborated to develop a common scope of work for inclusion in future contracts.
 - CBOs and MCOs agreed on standard data to be collected monthly and reported quarterly – contributing to improved service monitoring and identification of potential trends.
 - CBOs and MCOs successfully collaborate and problem solve as new areas of concern are identified.

State Team Achievements



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- What has our state team achieved, to date?
 - Made progress on pricing the relocation function.
 - Collected time study data from each CBO to capture time and effort.
 - Determined time study data inconclusive due to inconsistencies in data collection.
 - Decided to continue current pricing structure followed by additional analysis.
 - CBOs and MCOs support a per member per month pricing structure.
 - Need additional work on quality payment and Supplemental Transition Support payment process.

What's Next for Our State Team



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- Describe where your team is headed over the next few months....
 - Team agreed to meet quarterly to discuss pricing strategies and review performance data.
 - HHSC obtained Money Follows the Person Demonstration funds to support strategic planning for the CBOs.
 - Continue to develop a system to support transitions for children to ensure no child unnecessarily remains in a nursing facility.

Back to the Basics



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- This short video shows who benefits from this collaboration:
- Assistance in the Community for Complex Medical Needs video: <https://www.youtube.com/watch?v=9VYT-WnO8qM&feature=youtu.be>

Value Propositions

Value Propositions



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■ Environmental Scan

- What did you learn?
- What did you find as the common pain points/priorities of payers?

■ SWOT Analysis

- How can your organization address the needs of the payers you seek to work with?
- How can your organization address the needs of health care payers specifically?

After Lunch: Pitch to the Payers



39

- Health Plan pitch
- Value Proposition refinement
- Pitches
 - ▣ 2 minute pitch
 - ▣ 3 minute feedback
- Discussion/Feedback from payers
 - ▣ themes

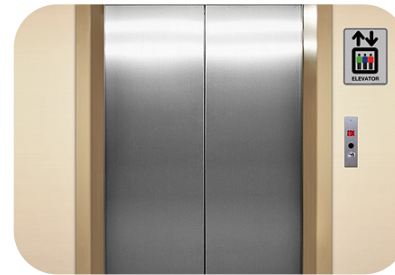
Value Proposition Activity



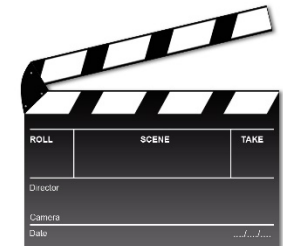
Outcomes, Service
and Data Cross-Walk



Business Model
Canvas



Elevator Pitch



Knowledge to Action

Outcomes, Service and Data Cross-Walk



POTENTIAL PAYER NEEDS OR OUTCOMES	CBO SERVICE	SERVICE IMPACT	WHAT IS THE EVIDENCE? WHERE IS THE DATA?
Consumer satisfaction			
Consumer engagement			
Community integration			
Employment placements			
Improved length of employment			
Improved health			
Reduced hospitalizations or nursing facility stays			
Reduced emergency room visits			
Reduced health and safety incidents			
Cost savings			
Improved ability to keep appointments			
Prompt initiation of services			
Improved performance on quality measures (e.g. NCI, NCI-AD, HEDIS)			
Improvements to Social Determinants of Health (SDoH)			

Business Model Canvas

Problem	Solution	Unique Value Prop	Unfair Advantage	Customer Segments
Existing Alternatives	Key Metrics		Channels	Early Adopters
Cost Structure		Revenue Streams		

Elevator Pitch



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- Who are you?
- What do you do?
- How do you do it?
- What do you deliver?
- Who do you work with?
- How do you add value to the person/organization you are speaking to?

Knowledge to Action

Target:			
Possible target population(s)		Defining characteristics	
The primary needs of the target population that our organization can address:			
Measurable high value outcome our organization can produce for the target population:			
Payer we will pursue first/next (e.g., health plan, ACO, health system, etc.)			
Name and type of payer		Its mission and major interest(s)/need(s)	
Key person to engage for contracting			
Barriers to securing a contract (e.g., policy, regulatory condition(s), etc.)?			
Our next step to further engage the contracting organization			
Champions who will endorse our network and open doors			
Name of champion	Organization	Who will make contact	Which target population/payer
#1.			
#2.			
#3.			
Competition and forces that we will need to address (Competition could include other CBO's, health care entities, etc.)			
Primary competitors	Major source of inertia we must overcome	Competitor's advantage vs. our advantage	
Action step(s) we will take in the next few weeks to improve our position in the market:			

Lunch and Plenary

See you back at 2:00P!

Pitch to the Payers

Health Plans



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- Rick Fredrickson
 - ▣ Centene Corporation
- Patricia Nobbie, Director, Disability Policy Engagement
 - ▣ Anthem, Inc.
- Joy Missick
 - ▣ Molina Healthcare

Pitch to the Payers



48

- Health Plan pitch
- Value Proposition refinement
- Pitches
 - ▣ 2 minute pitch
 - ▣ 3 minute feedback
- Discussion/Feedback from payers
 - ▣ themes

VALUE PROPOSITIONS – 201 LEVEL

VALUE BASED REIMBURSEMENT

TAMYRA PORTER, DIRECTOR, NAVIGANT

NASUAD National Home and Community Based Services Conference

August 28, 2019



AGENDA

- Introductions
- Continuum of Payment Methodologies – Degree of Risk Sharing
- How to Price the Services your Organization Offers
- How to Demonstrate Outcomes on Services
- Collecting Data and Demonstrating Goal Attainment
- Q&A
- Appendix

INTRODUCTIONS



Tamyra Porter
Director

- Brings over 19 years of experience working on the design, implementation and oversight of Medicaid programs
- Directs many of Navigant's LTSS engagements including work in PA, IO, AL, AR, KY, NH and with CMS
- Fluent in facilitating multi-agency design discussions for waiver and contract development
- Led various quality improvement projects rooted in principles of value based purchasing as a driver of compliance monitoring
- Led various readiness reviews for Medicaid managed care
- Keen eye for operational effectiveness and efficiencies including roles in development and implementation of technology solutions that support these processes

CONTINUUM OF PAYMENT METHODOLOGIES AND DEGREE OF RISK SHARING

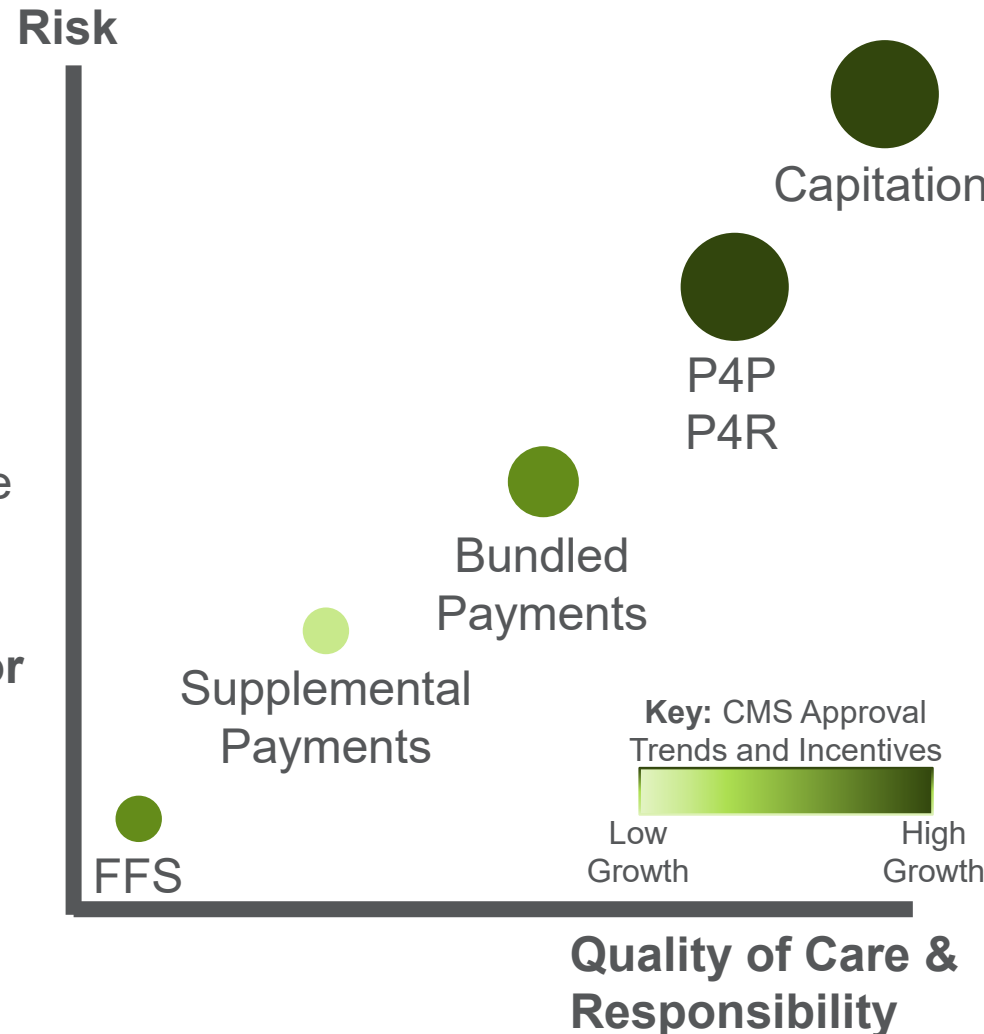
VALUE BASED PAYMENTS

What does value based care mean in Home and Community Based Services (HCBS)?

- Value-based payment (VBP) methodologies are payment initiatives aimed at prioritizing individual outcomes. VBP intends to improve quality and efficiency of care by incorporating innovative payment models.
- VBP in HCBS may utilize existing Fee-For-Service (FFS) payment systems, thus allowing incremental transitions to broader value-based systems, policies, and mindsets.
 - Supplemental payments are one method states can use to leverage existing FFS payment systems to further State Medicaid Agency goals, support quality initiatives, and/or reinforce preferred individual outcomes.
- VBP alone is not likely to drive quality and efficiency, but can be very effective when paired with other strategies to promote continuous quality improvement (increased training, quality improvement initiatives, etc.)

DEGREES OF RISK SHARING

1. **Fee-for-Service (FFS):** A direct, 1:1, payment for services rendered.
2. **Supplemental Payments:** Federally authorized additional payments to hospitals to pay for services rendered to Medicaid patients.
3. **Bundled Payments:** A single, lump sum payment to treat an entire episode care regardless of the number of services rendered.
4. **Pay for Performance (P4P) or Pay for Results (P4R):** A core payment enhanced with bonuses based on various outcomes and targets.
5. **Capitation:** A fixed payment per patient to cover medical or other care.



VALUE BASED PAYMENT “TACTICS”

How do VBP “tactics” tend to play out?

- Supplemental “task-based” payments
 - *Example:* the payor will pay an established amount to complete a training or incorporate a technology upgrade
- Tiered payments
 - *Example:* the payor pays an increased rate to provide case management services to participants with a higher severity of need
- Pay-for-performance
 - *Example:* Providers who score above a certain threshold on participant surveys will receive an elevated reimbursement rate for the next year
- Non-financial incentives
 - Developing “report card” like comparative reporting released publicly
 - Public credential – like the “Good Housekeeping Seal” for providers
 - Selective contracting

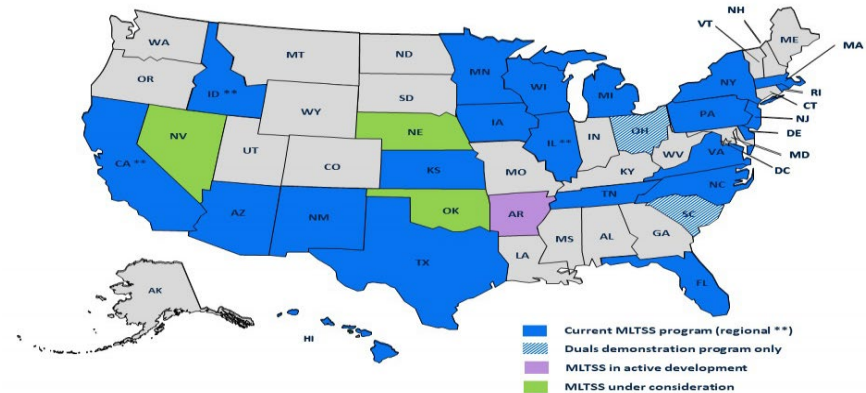
VBP ENTITIES AND PARTNERS

What kinds of entities do you need to keep your eye on – who may be considering VBP for HCBS?

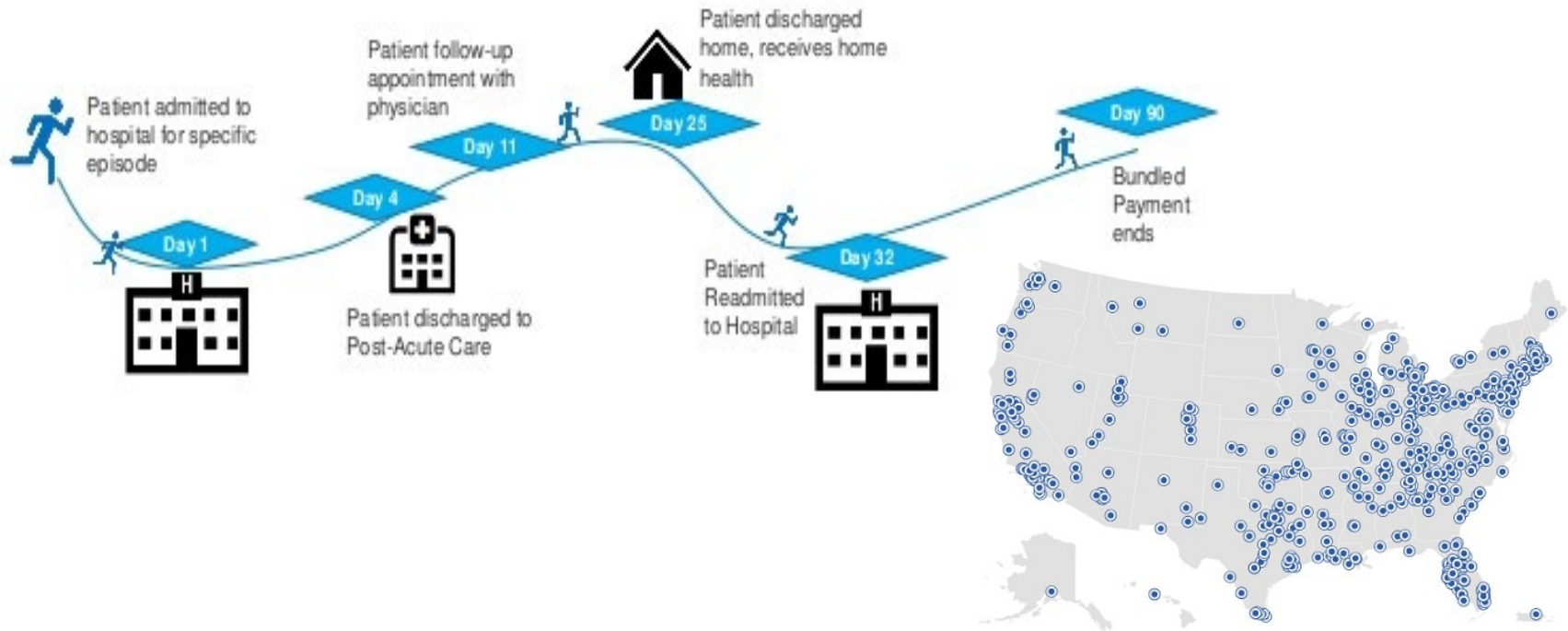
- State Medicaid Unit
- Healthcare systems who are payors (pay-vidors)
- Primary care entering into risk arrangements
- Medicare Advantage plans and Special Needs Plans

STATES AND HCBS VBP

- **State VBP strategies that focus on setting APM targets and allow MCO flexibility** – *Arizona, Iowa, South Carolina, Texas and Virginia*
- **State strategies that prescribe in some areas (e.g., quality measure set and reporting) and allow for flexibility in others (e.g., payment model)** – *Minnesota*
- **State strategies that may be more specific around state-defined payment models or contracting requirements** – *Rhode Island and Tennessee*
- *Others embedded with in MLTSS*



BPCI Advanced Clinical Episode Example



Source: Centers for Medicare & Medicaid Services

MEDICARE HOSPITAL PENALTIES/MEASURES

Medicare Eligible Hospital Program	What's Measured	Reimbursement Impact
Hospital Readmissions Reduction Program (HRRP)	<p>Measures assess all-cause unplanned readmissions for patients with principal discharge diagnosis for one of the six conditions or procedures (AMI, HF, pneumonia, COPD, CABG, or THA/TKA) that occur within 30 days of discharge from the index (i.e. initial) admission to the same or another applicable acute care hospital.</p> <p>Readmissions to any applicable acute care hospital are counted, regardless of the principal diagnosis, because for a patient a readmission from any cause is an adverse event.</p>	<p>Low-performers subject to penalties of up to 3% of Total Medicare Inpatient Revenues</p> <ul style="list-style-type: none"> 80% of the 3,241 hospitals CMS evaluated this year will face penalties in 2018, with CMS withholding \$564 million in payments over the next year
Hospital Acquired Conditions Reduction Program (HACRP)	AHRQ PSI 90 Composite, NHSN HAI measures [Central Line-Associated Bloodstream Infection (CLABSI), Catheter-Associated Urinary Tract Infection (CAUTI), Surgical Site Infection (SSI), Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia, and Clostridium difficile Infection (CDI)]	Reduces up to 1% payment reduction to hospitals that rank in the worst-performing quartile of all subsection (d) non-Maryland hospitals.
Deficit Reduction Act Hospital Acquired Conditions (DRA HAC)	Measures for 14 HAC that are: (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence-based guidelines.	Hospitals do NOT receive additional payment for cases in which one of the selected conditions was not present on admission.
Hospital Value-based Purchasing Program (HVBP)	Measures hospitals efforts to eliminate or reducing the occurrence of adverse events (healthcare errors resulting in patient harm), adopting evidence-based care standards and protocols that result in the best outcomes for the most patients, re-engineering hospital processes that improve patients' experience of care, Increasing the transparency of care for consumers, and provision high-quality care at a lower cost to Medicare.	Adjusts payments to hospitals for inpatient services up or down by 2%

VBP SERVICES

What are some of the services well positioned for VBP?

- **Information and Referral** – how effectively does your organization link referees to community services?
- **Case Management / Care Coordination** – do you effectively administer person-centered service planning and manage the plan of care?
- **Care Transitions** – are care transitions conducted efficiently and help to deter acute care utilization and rehospitalization?
- **Supported Employment** – are you supporting participants to obtain and sustain community-based employment?
- **Behavioral Supports** – are behavioral supports and therapies reducing symptoms and preventing use of higher-cost therapies and acute care?
- **Other HCBS** – are in-home or congregate services delivered in a manner that garners high participant satisfaction?

EXPANSION OF MEDICARE ADVANTAGE SERVICES

Adult day care services

- 26

- Services provided outside the home such as assistance with ADLs/IADLs, education to support performance of ADLs/IADLs, physical maintenance/rehabilitation activities, and social work services targeted to ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and health care utilization
- Recreational or social activities or meals that are ancillary to primarily health-related services and items may also be provided, but the primary purpose of adult day care services must be health-related and provided by staff whose qualifications and/or supervision meet state licensing requirements. Transportation to and from the adult day care facility may be provided and should be included

Home-based palliative care

- Home-based palliative care services to diminish symptoms of terminally ill members with a life expectancy of greater than six months not covered by Medicare (e.g., palliative nursing and social work services in the home not covered by Medicare Part A)
- Medicare covers hospice care if a doctor and/or the hospice medical director certify the patient is terminally ill and has six months or less to live

In-home support services - 107

- In-home support services to assist individuals with disabilities and/or medical conditions in performing ADLs and IADLs within the home to compensate for physical impairments, ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and health care utilization. Services must be provided by individuals licensed by the state to provide personal care services, or in a manner that is otherwise consistent with state requirements.

EXPANSION OF MEDICARE ADVANTAGE SERVICES

Respite support for caregivers of enrollees – 429 plans

- Respite care provided through a personal care attendant or the provision of short-term institutional-based care, as appropriate, to ameliorate the enrollees' injuries or health conditions, or reduce the enrollees' avoidable emergency and health care utilization
- Respite care should be for short periods of time (e.g., a few hours each week, a two-week period, a four-week period) and may include services such as counseling and training courses for caregivers of enrollees.

Medically approved non-opioid pain management

- Medically approved non-opioid pain treatment alternatives, including therapeutic massage furnished by a state licensed massage therapist
- The non-opioid pain management item or service must treat or ameliorate the impact of an injury or illness (e.g., pain, stiffness, loss of range of motion)

Stand-alone memory fitness benefit

- Memory fitness benefit may be incorporated as a component of a health education benefit and/or offered as a standalone benefit
- The benefits and activities must be primarily for the prevention, treatment, or amelioration of the functional/psychological impact of injuries or health conditions

EXPANSION OF MEDICARE ADVANTAGE SERVICES

Home and bathroom safety devices and modifications

- Non-Medicare-covered safety devices to prevent injuries in the home and/or bathroom. Plans may also offer installation
- The benefit may include a home and/or bathroom safety inspection conducted by a qualified health professional, in accordance with applicable state and Federal requirements, to identify the need for safety devices and/or modifications, as well as the applicability of the device or modification to the specific enrollee's needs and home

Transportation

- Transportation to obtain non-emergent, covered Part A, Part B, Part D, and supplemental benefit items and services to accommodate the enrollee's health care needs
- For example, transportation for physician office visits.
- Transportation must be arranged, or directly provided, by the plan and may not be used to transport enrollees for purposes that are not health related.

Over-the-counter health-related items and medications

- Health-related items and medications that are available without a prescription, and are not covered by Medicare Part A, Part B, or Part D.
- Phone-based Social Worker

KEY TAKE-AWAY

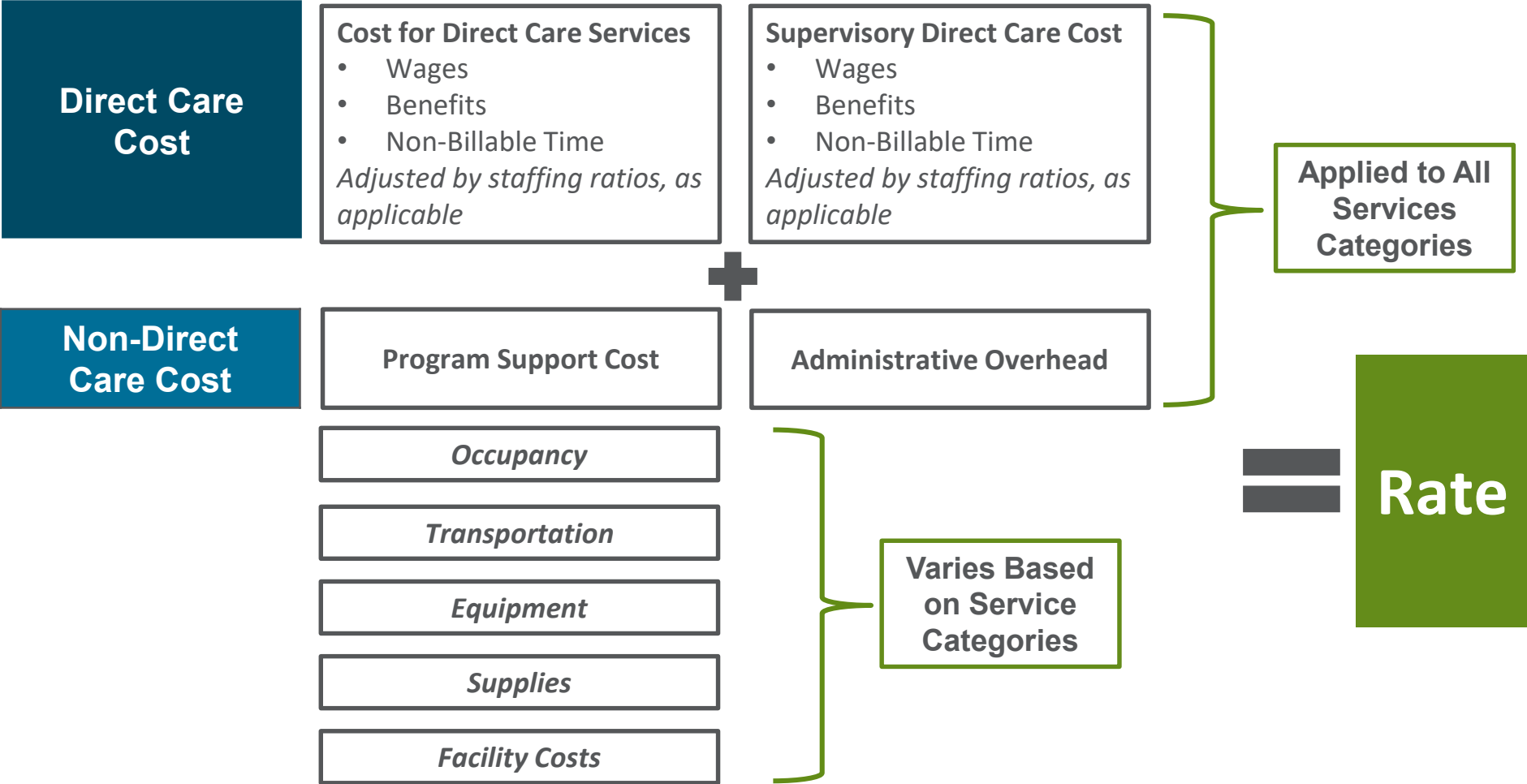
- **Understand how payers are aligning for VBP**
- **Assess how your services can support payers in achieving VBP goals**
- **Understand your ability to manage risk**
- *Negotiate on risk/VBP arrangements*
- *Collect data to evaluate your success*

HOW TO PRICE SERVICES

KEY COMPONENTS OF PRICING IN VBP



OVERVIEW OF RATE BUILD-UP APPROACH





- What measures are you influencing?
- Can you collect data to track performance against those measures?
- Are terms clear?
- Do the potential gains cover the additional administrative costs for the VBP dynamic?
- How will the arrangement change your business model overall?

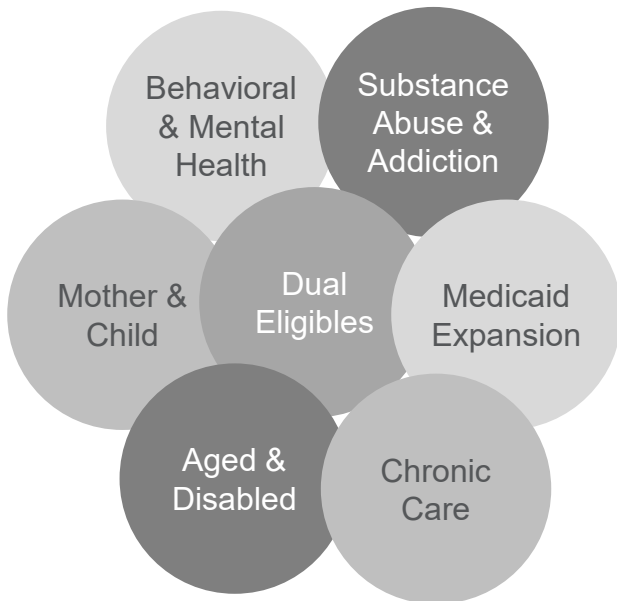
ESTABLISHING VBP ARRANGEMENTS

- A care model and VBP arrangement must be specific to the target population

Step 1:

Determine which populations will require programmatic approaches

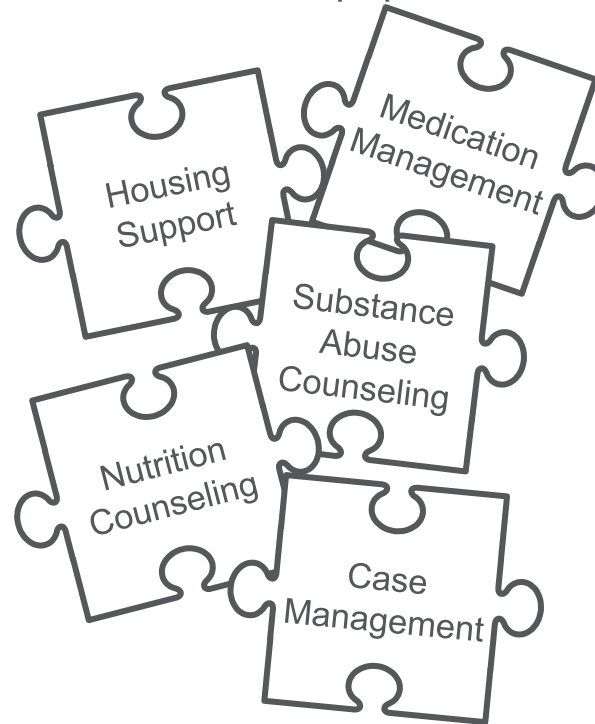
May include...



(not mutually exclusive)

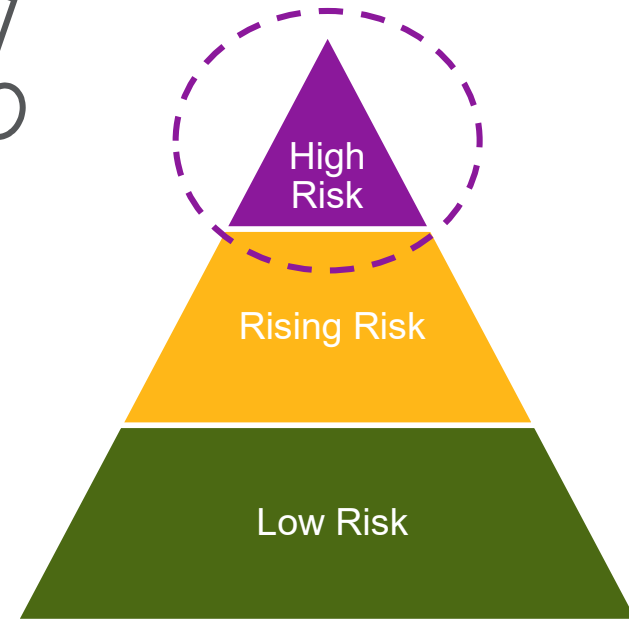
Step 2:

Create standardized comprehensive approaches for each of these populations



Step 3:

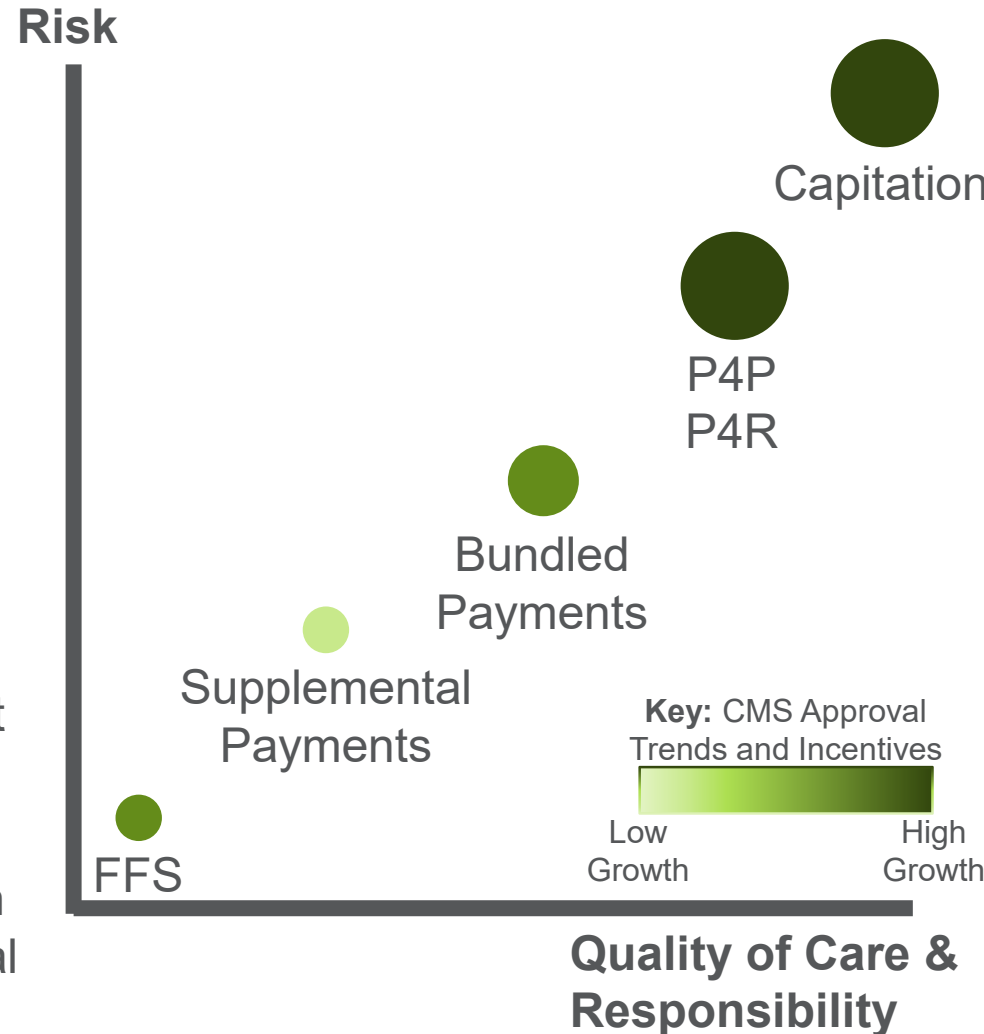
Stratify populations by risk to ensure interventions are effectively allocated



HOW TO DEMONSTRATE OUTCOMES - EXAMPLES

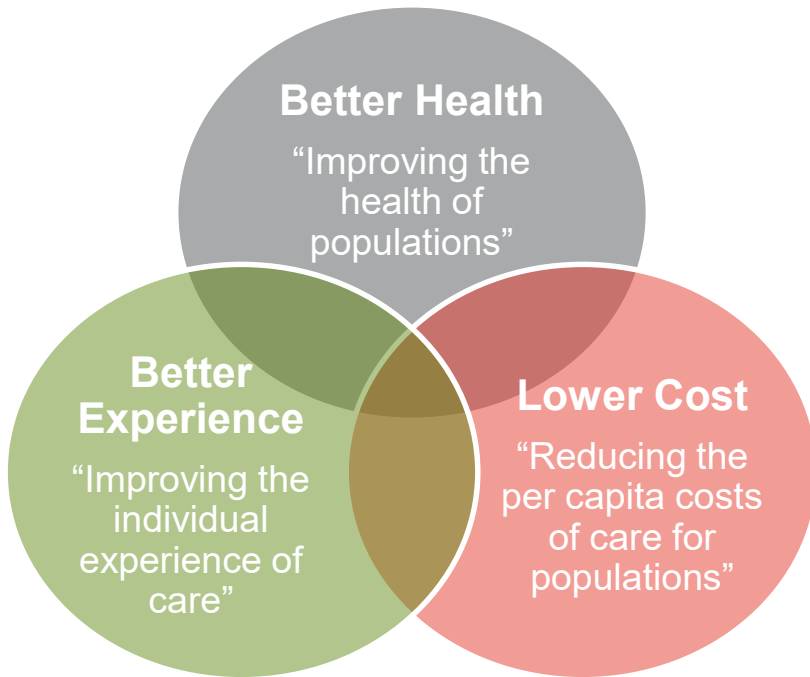
PAYER PRIORITIES AND TRENDS

- Payers continue to move from FFS to capitation in contracting
 - Both to managed care organizations (MCOs) and passing capitation down to other providers
- Federal scrutiny of Medicare patient readmissions continue
- All types of value-based payment heavily rely on appropriate, lower cost care outside of hospitals (e.g., HCBS)
- Payers often increase prior authorizations, narrow networks and set protocols increase as risk increases
- Payers increasingly acknowledge that existing community based networks can wrap around patients and address social determinants of health



CASE EXAMPLE 1: POST ACUTE AS A PILLAR OF CARE

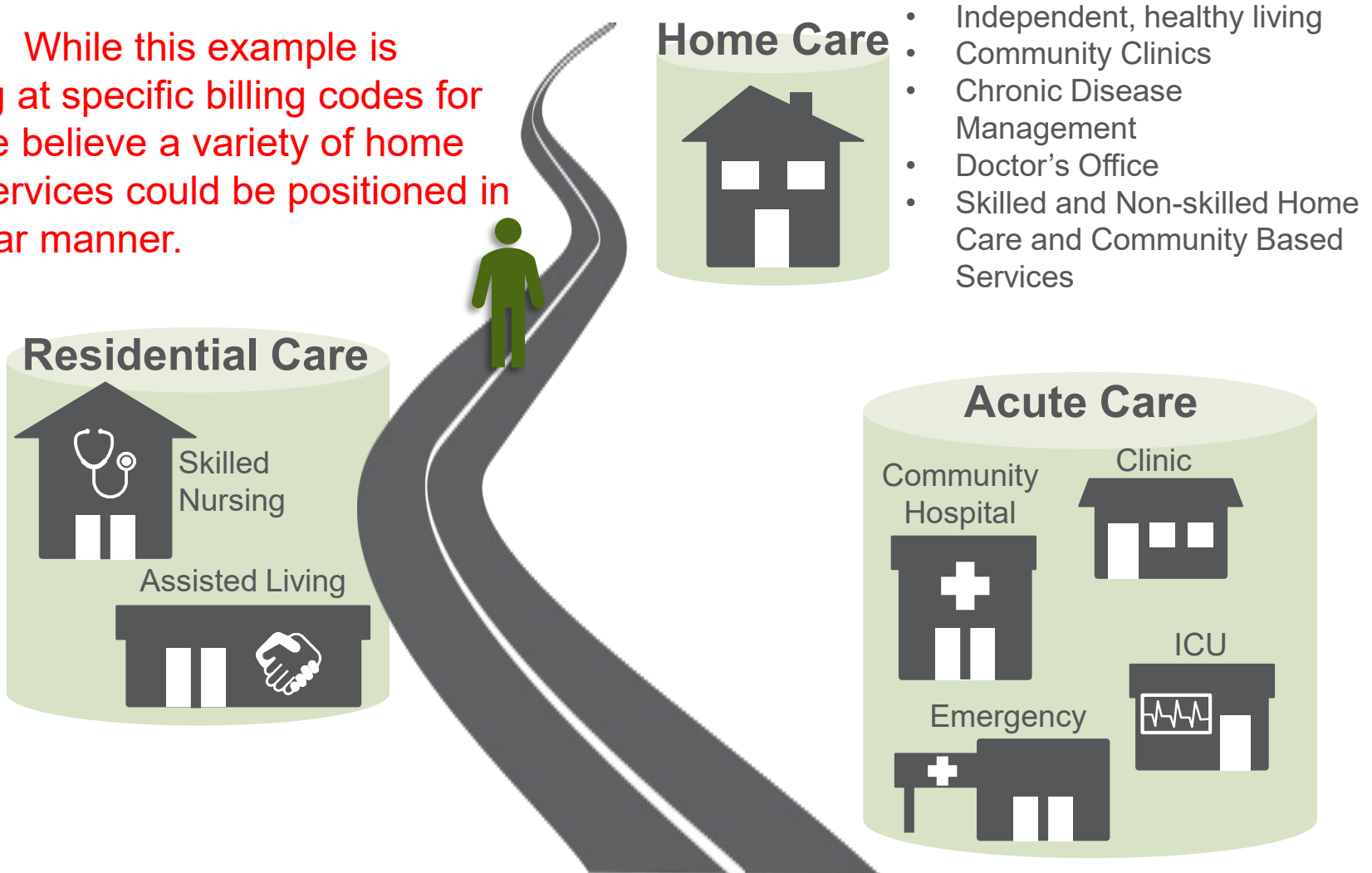
- Payers are focused on achieving the Triple Aim (achieving better health and experience for patients at a lower cost)
- Quality post acute care drives results that align with the Triple Aim



Aim	Home Health Benefit
Better Health	<ul style="list-style-type: none"> • Less adverse events • Lower mortality
Better Experience	<ul style="list-style-type: none"> • Patient preference • Integration back into community • Lower patient cost
Lower Cost	<ul style="list-style-type: none"> • Reduction in readmissions • Lower cost to care

PERSON CENTERED CARE THAT DRIVES QUALITY, PATIENT ENGAGEMENT, AND LOWERS THE COST OF CARE

NOTE: While this example is looking at specific billing codes for HH, we believe a variety of home care services could be positioned in a similar manner.



- Independent, healthy living
- Community Clinics
- Chronic Disease Management
- Doctor's Office
- Skilled and Non-skilled Home Care and Community Based Services

HOME CARE IMPACTS

- Home health is significantly more cost effective per episode and has increased quality of care due to a shorter length of stay
- SNF vs home health Medicare comparison, 2014 data

Metric	SNF	HH
Average Payment/Episode	\$16,107 - \$22,728	\$2,689
Average Margin	11.8%	10.8%
Average Length of Stay / Episode (Visits / Episode)	40 days	17.5 days
Discharge to Community	37.3%	-
30-Day Hospital Readmission Rate	10.9%	-

Source: <http://www.medpac.gov/docs/default-source/data-book/june-2016-data-book-section-8-post-acute-care.pdf?sfvrsn=0>

HOME HEALTH UTILIZATION IS INCREASING

- Risk bearing providers are increasingly using home health as they look to reduce total episode costs

SKILLED NURSING FACILITY

HOME HEALTH

**Discharge
Location**

40%

31%

**Total Average
Spending**

\$27,990

\$16,755

- Medicare spends *nearly twice as much* for joint replacement episodes when the beneficiary is discharged to a SNF compared to home health
- Post-acute care and readmissions account for nearly 40 percent of Medicare spending for 30-day CHF episodes and 37 percent of spending for joint replacement episodes

Source: IOM NRC Workshop “ The Future of Home Health Care

AHA STUDIES SHOW HIGHER READMISSION AND MORTALITY RATES AMONG MEDICARE BENEFICIARIES DISCHARGED TO SNFS VS HOME HEALTH

SKILLED NURSING FACILITY

HOME HEALTH

30-Day
Mortality

14.4%

4.1%

30-Day Re-
hospitalization

27.0%

23.5%

One-Year
Mortality

53.5%

29.1%

One-Year Re-
hospitalization

76.1%

72.2%

Source: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4096790/pdf/nihms601319.pdf> (2012)

AN OIG REPORT ESTIMATED ABOUT A THIRD OF MEDICARE BENEFICIARIES EXPERIENCED ADVERSE EVENTS OR TEMPORARY HARM DURING SNF STAYS

ADVERSE EVENTS

22%

Medicare beneficiaries experienced adverse events during their SNF stays

TEMPORARY HARM

11%

Medicare beneficiaries experienced temporary harm events during their SNF stays

59%

of these adverse events and temporary harm events were clearly or likely preventable and due to inadequate resident monitoring or failure / delay of necessary care

Source: "Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries." Feb. 2014 <https://oig.hhs.gov/oei/reports/oei-06-11-00370.pdf>
Data Time Period: 2008 -2012

HOME HEALTH READMISSION RATES FOR MEDICARE BENEFICIARIES ARE DIRECTLY RELATED TO THE NUMBER OF HOME HEALTH VISITS IN THE FIRST WEEK AFTER DISCHARGE

# or Visits	1	2	3	4	5	6	7
National Readmission Rate	36.5%	15.5%	11.4%	10.7%	10.6%	9.9%	9.8%

The amount of time that lapses between an inpatient discharge and the first home health visit also influences readmission rates, data show.

Days from Discharge to Visit	Same Day	1	2	3	4
SHP Analysis	14.1%	12.1%	12.9%	12.9%	13.3%

The day a patient is discharged to home health impacts the readmission risk with Thursday – Saturday being the ideal days.

Day of Discharge	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
SHP Analysis	12.1%	13.4%	13.3%	12.2%	11.4%	11.9%	11.6%

Source: Strategic Health Partners Analysis, 2017
<https://www.shpdata.com/blog/how-home-health-can-win-the-readmissions-numbers-game/>

HOME HEALTH CARE HAS STRONG PERFORMANCE ON QUALITY MEASURES RELATED TO PATIENT CARE

National Averages for How Often Home Health Met Quality Measures Related to Patient Care, 2011 – 2016

Measure	2011	2012	2013	2014	2015	2016
Checked patients for pain	98%	99%	99%	99%	99%	99%
Checked patients for risk of developing pressure sores	98%	98%	99%	99%	99%	99%
Treated heart failure symptoms	98%	98%	98%	98%	98%	98%
Treated patients' pain	97%	98%	98%	98%	99%	99%
Checked patients for depression	97%	97%	98%	98%	98%	98%
Checked patients' risk of falling	95%	94%	98%	98%	98%	99%
Included treatments to prevent pressure sores in the plan of care	95%	96%	97%	98%	98%	98%
Took doctor-ordered action to prevent pressure sores	94%	95%	96%	97%	97%	98%
For diabetic patients, got doctor's orders, gave and educated about foot care	91%	93%	94%	95%	95%	96%
Taught patients (or their family caregivers) about their drugs	89%	92%	93%	93%	94%	96%
Began care in a timely manner	90%	92%	92%	92%	92%	92%
Determined whether patients received a flu shot for the current flu season	67%	69%	72%	73%	71%	69%
Determined whether patients received a pneumococcal vaccine (pneumonia shot)	65%	68%	71%	73%	72%	73%

Source: Center of Medicare and Medicaid Services, Medicare Home Health Compare

HOME HEALTH PATIENT OUTCOMES ARE IMPROVING

National Averages for Patient Outcomes while in Home Health Care 2011 – 2016

Measure	2011	2012	2013	2014	2015	2016
Wounds improved or healed after operation	88%	89%	89%	89%	99%	90%
Got better at bathing	65%	66%	67%	68%	69%	71%
Had less pain when moving around	66%	67%	68%	68%	68%	70%
Breathing improved	63%	64%	65%	65%	66%	69%
Got better at walking or moving around	56%	59%	61%	63%	64%	66%
Got better at getting in and out of bed	54%	55%	57%	59%	59%	62%
Got better at taking drugs correctly by mouth	47%	49%	51%	53%	53%	56%
Had to be admitted to a hospital	N/A	17%	16%	16%	16%	16%
Needed any urgent unplanned care in the hospital emergency room – without being admitted to the hospital	N/A	12%	12%	12%	12%	12%

Source: Center of Medicare and Medicaid Services, Medicare Home Health Compare

CASE EXAMPLE 2

Goals	Outcomes Desired
<ul style="list-style-type: none">• Place participants in competitive integrated employment settings.• Align supports with person-centered care plans.• Increase participant independence.	<ul style="list-style-type: none">• Providers should complete a job exploration assessment that aligns with the individual’s person-centered service plan.• Providers should actively work with the individual to obtain and then retain their job.• Providers should coach participants with a goal of achieving greater independence at work, thus minimizing the need for continued provider supports.• State should see a reduction in costs for supported employment services.

CASE EXAMPLE

STEP 3: IMPLEMENT INCENTIVES PLAN(S)

- The state elects to implement a pay-for-performance incentive payment plan that prioritizes and emphasizes the purpose of the waiver program while also meeting state and individual goals:
 - The state elects to reimburse providers using a lump-sum payment regardless of hours spent for **successful completion of a job assessment tool**.
 - The state uses a lump sum payment to reward providers when an **individual obtains employment** and discourages continuous FFS billing by capping the number of pre-employment vocational support hours annually.
 - The state encourages long-term employment and reduction of supports by linking job coaching reimbursement **to the number of hours the supported individual works**.

CASE EXAMPLE

IMPLEMENT INCENTIVE PLAN(S): JOB COACHING

- The state authorizes job coaching in an individual's person-centered service plan to promote **sustained individual integrated employment**.
 - Job coaching services are categorized as initial, ongoing, and monitoring services, with the expectation that the intensity of supports will decrease over time **as the individual achieves greater independence**.
 - The state pays a monthly monitoring payment to providers once an individual has obtained employment and requires less than three direct support hours per week of supported employment services.
 - Providers are reimbursed an hourly rate based on individual acuity, the length of time an individual maintains employment, and the amount of support the individual needs to maintain employment.

CASE EXAMPLE

IMPLEMENT INCENTIVE PLAN(S): JOB COACHING

- The state promotes individual independence by tying increased provider reimbursement to the fading of supports.
 - The state pays for supported employment services on a three-tier prospective rate basis. The tiers are each based on the level of “fading” achieved and the waiver participant’s level of disability.
 - The level of fading is determined by the ratio of direct support hours the job coach provides per week to the number of hours the individual works per week in an integrated job setting.
 - As the individual increases independence on the job, the provider fades the number of hours for job coaching.
 - Providers qualify for the increased hourly rate by meeting certain service reduction targets identified in the individual’s person-centered service plan. The state pays a monthly monitoring payment to providers once an individual has obtained employment and requires less than one hour per week of supported employment services. This payment promotes outcome-based care and rewards providers outside of a traditional FFS quantity of care based arrangement.

CASE EXAMPLE 2

IMPLEMENT INCENTIVE PLANS(S): JOB COACHING

- The state encourages **long-term employment** and **fading of supports** by linking job coaching reimbursement to the number of hours the supported individual works.

Months on Job	% of direct support hours	Acuity 1 Rate	% of direct support hours	Acuity 2 Rate
Initial: < 6 months		\$23.40/hour		\$25.20/hour
Ongoing: 6-24 months	Tier 1: 80-100%	\$18.72/hour	Tier 1: 90-100%	\$20.16/hour
	Tier 2: 60-79%	\$21.06/hour	Tier 2: 80-89%	\$22.68/hour
	Tier 3: < 60%	\$23.40/hour	Tier 3: < 80%	\$25.20/hour
Monitoring: > 24 months		\$117.00/month		\$117.00/month

- Providers are eligible for a base rate the first six month of employment without regard to fading. After six months, the provider retains the base payment rate **only** if optimal fading targets are achieved. If optimal fading does not occur, providers are eligible for 80-90% of the base rate based on the amount of fading achieved.
- Providers are eligible for a monthly monitoring payment when individuals require three direct support hours or less per week.

CASE EXAMPLE 2, CONT.

- Evaluation 1: The state notices that only five percent of its providers qualified for the monitoring payment that rewards providers when individuals require less than three hours of direct support per week.
 - The state reviews claims data to better align incentives with performance and updates its incentive program to reward providers when individuals require five direct support hours or less per week. Using last year's data, the state determines that thirty-five percent of providers would have been eligible for the incentive payment.
- Evaluation 2: The state also reviews provider documentation to ensure that lump sum payments remain appropriate to retain an adequate and qualified provider pool.
 - The state reviews documentation to determine the time spent developing and completing the job assessment tool. The state compares the time spent with the lump sum payment to assess whether the payment is adequately reimbursing providers for their time.

COLLECTING DATA AND DEMONSTRATING GOAL ATTAINMENT

KEY CRITERIA FOR SUCCESS

- **Clarity:** Know the following in advance and prior to entering the agreement
 - Participate in statewide and payer specific provider engagement opportunities to influence rates
 - Raise challenges
 - Identify rate enhancements (e.g., travel, productivity, technology)
 - Understand the outcomes and measures in your contract
 - Obtain access to data against which you will be evaluated:
 - Collecting (internal vs external)
 - Aggregating
 - Reporting
- **Staffing:** Use appropriate staffing models
 - Collaborate with case managers as appropriate
 - Pay a competitive rate to retain staff
- **Technology and Data:** Make sure you have the resources and data available for success
 - Implement Data Sharing Agreements with payer and provider partners
 - Understand payer prior auth and referral patterns

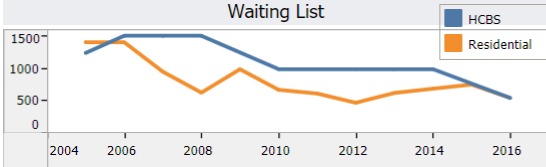
Additional Highlights

2019 Rank (best = 1, worst = 51)

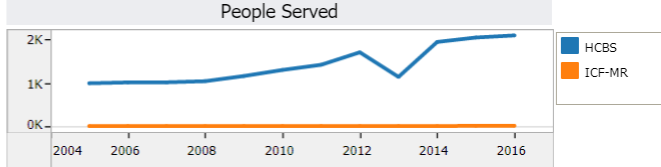
40

Alaska has no large state facility keeping Americans isolated from the community.
 Alaska participates in the National Core Indicators, the premier quality assurance program but did not report their NCI survey data.
 Alaska has a waiting list that would require the program to grow by 26% on average to accommodate the need.

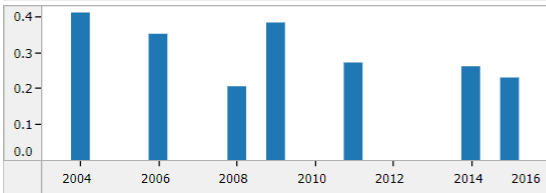
Waiting List



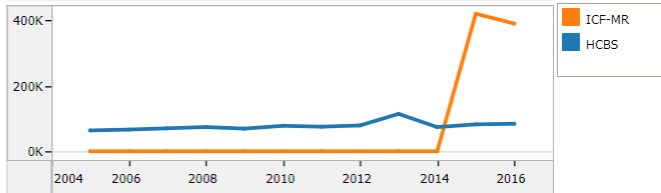
People Served



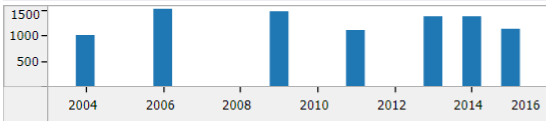
Supported or Competitive Employment



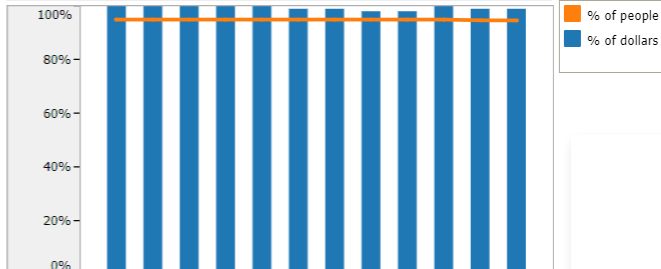
Average Cost per Person



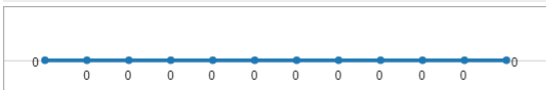
Number of Families Receiving Support



People & Dollars in the Community (HCBS)



Number of Residents in Large State Facilities



<http://caseforinclusion.org/data/state-scorecards>

Q&A

Wrap-Up: Day 1

Wrap-Up Day 1



92

- Dinner tonight at 6:30 pm
 - ▣ Fells Point Tavern, 1606 Thames Street

- Business Acumen Learning Collaborative Day Two
 - ▣ Tuesday, August 27th from 10:30 am – 2:30 pm in Heron

- Business Development Learning Collaborative Day Two
 - ▣ Tuesday, August 27th from 2:45 pm – 5:30 pm in Heron

Join Us!

**Both groups are welcome to
attend the others' sessions**

DAY 2: BUSINESS ACUMEN LEARNING COLLABORATIVE

Tuesday, August 27, 2019

Day 2:

Today's Agenda - Business Acumen



94

- Value-Based Payment
 - ▣ Esme Grant-Grewal, ANCOR

- Quality Measurement & Outcomes
 - ▣ Kathy Carmody, Institute on Public Policy for People with Disabilities

- Integrating Value-Based Payment, Quality Measures & Outcomes
 - ▣ Group Activity

- Toolkit Review
 - ▣ Erica Lindquist

- Toolkit Refinement
 - ▣ Group Activity



Value-Based Payment

Esme Grant Grewal,
VP for Government Relations,
ANCOR

Business Acumen Learning Collaborative and Value Based Payments

Esmé Grant Grewal, Esq.

Vice President of Government Relations, ANCOR

August 27 2019



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**Advancing Value & Quality in
Medicaid Service Delivery for
Individuals with Intellectual &
Developmental Disabilities**



*A report published by the American Network of Community Options and Resources
January 2019*



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Defining Key Terms

This report uses the following terms:

- **Alternative Payment Models (APMs)** are strategies that change the way Medicaid providers are paid, moving away from FFS payments to methods of payment that incentivize value. APMs can be implemented in different delivery systems, including FFS Medicaid programs and in Medicaid managed care.²
- **Value-Based Payment (VBP)** models are payment models in which a state Medicaid program holds a provider or a managed care organization accountable for the costs and quality of care they provide or pay for.³
- **Fee-for Service (FFS)** models are those in which payments are made for a service or unit of service that is delivered, and where payments vary based on unit of service.⁴ Fee-for-service includes payments that are made based on time-based billing increments during which the services are provided (monthly, daily, hourly, or half hourly rates).
- **Capitation** is a payment model in which payments are made based on the numbers of people enrolled or served in the expectation that services are provided rather than being based on the specific services that are delivered.⁵
- **Managed Long-Term Services and Supports (MLTSS)** programs are arrangements wherein states contract with managed care plans to deliver LTSS either as a stand-alone benefit, or as part of a comprehensive package of physical and behavioral and LTSS. These programs are generally capitated. MLTSS is not an APM, but APMs and VBPs can be integrated into MLTSS.

Quality Measurement

States with at least one quality measure

51

States that measure beneficiary quality of life

48

States that measure community integration

42

States that use LTSS rebalancing measures

17



Payment Reforms Should Support Goals for HCBS Services for People with I/DD

Such as...


- ✓ Helping individuals with I/DD achieve life goals
- ✓ Helping people move from institutions to home, family and community settings
- ✓ Providing stability and develop lifelong relationships and trust with individuals and families
- ✓ Empowering people with disabilities to make important life choices
- ✓ Advancing self-direction
- ✓ Supporting caregivers



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Goals and Challenges: Paying for Value in MLTSS

Value Based Payment Objectives



Integration of Physical, Behavioral Health, & LTSS



Coordination of Complex Populations



Managing Costs



Improving Outcomes

Value Based Payment Challenges



Individual & Family Engagement



Developing Payment Methods



Payer/Provider Collaboration



Workforce Challenges



Culture Change



Care Coordination

State Programs that Are Leading Payment Innovation

• Arizona • Arkansas • Kansas • Michigan • New York (3 models) • Pennsylvania • Tennessee • Wisconsin

New York: Fully Integrated Dual Advantage plan for people with I/DD dually eligible for Medicare and Medicaid; health home care coordination models; shared savings program

Pennsylvania: Provider-lead adult Community Autism Program accepts risk and shares risk with providers, provides flexible services provision and has a strong staffing approach

Tennessee: Employment and Community First Choices Program provides integrated, comprehensive service package of physical, behavioral, and LTSS through commercial MCOs. Expanded to I/DD in 2016; focus on training and career ladder for direct service workers



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Quality Measurement & Outcomes

Kathy Carmody, CEO

Institute on Public Policy for People with
Disabilities

Building the Framework for I/DD Quality Measures



Agenda

- Why we came together
 - Approach to exploring quality measures
 - What we learned
 - What's next
-



I/DD Quality Measures

We brought together thought leaders from throughout the healthcare, LTSS and I/DD fields for the purpose of developing a common understanding of value-based quality measures for people with IDD to ensure that should the industry moves to managed care, the quality metrics utilized are meaningful for people with IDD.



Volume Vs. Value

The industry-wide shift in health care delivery from paying for volume (i.e. units of service) to value (i.e. outcomes) is impacting how payers (i.e. state Medicaid agencies) view long term services and supports (LTSS) being delivered to people with intellectual and developmental disabilities (I/DD).



Defining Value

The HEDIS (Healthcare Effectiveness Data and Information Set) measures which govern much of the managed care health delivery system are process and health care delivery focused items. While not irrelevant to the wellbeing of people with I/DD, they don't capture or reflect the nature of services delivered by community organizations to people with I/DD.



Who Defines Value

Our interest was assuring that people with expertise in I/DD services, including people who receive services, families and service providers had a strong voice in helping to shape the standards and processes by which value in I/DD services would be defined and measured.



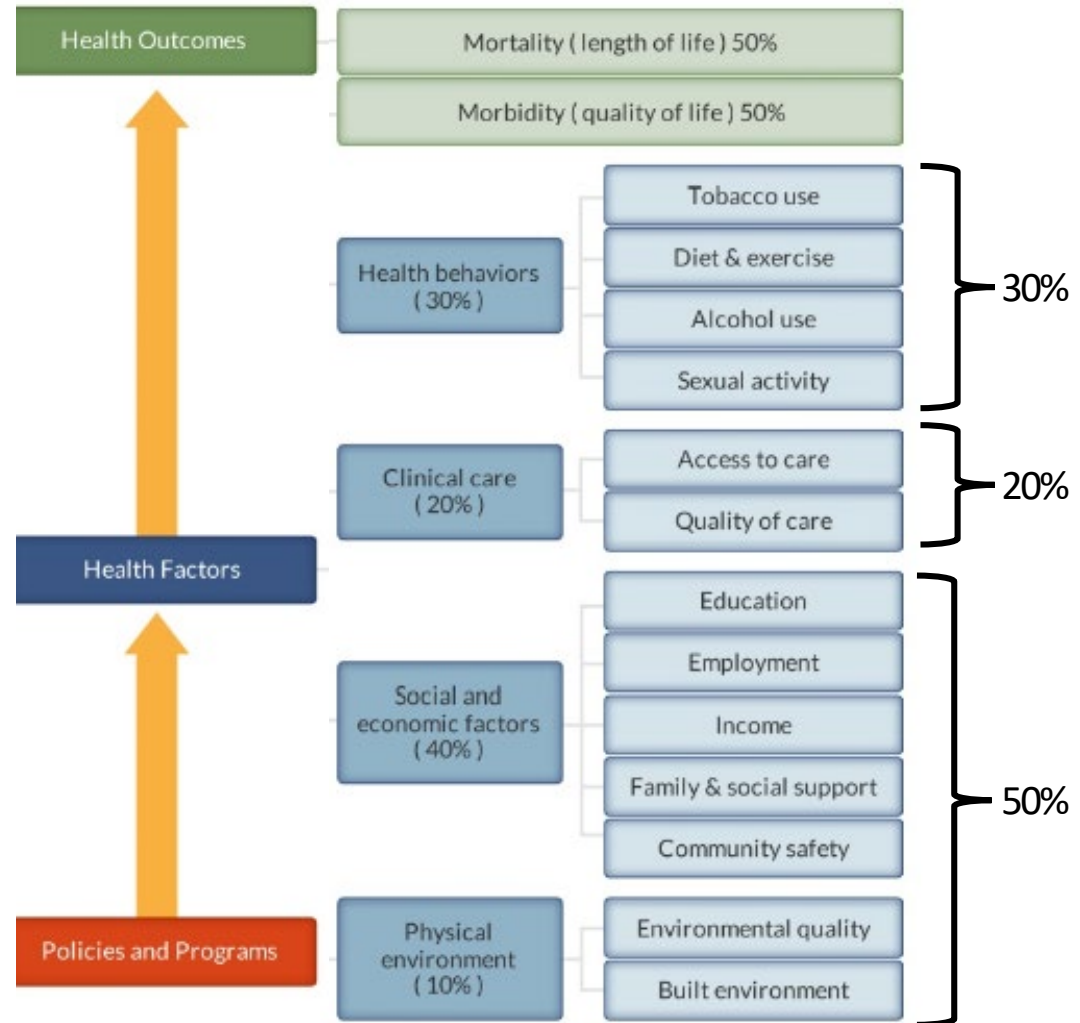
Social Determinants of Health

80% of health care costs are related to factors outside the actual delivery of health care, such as food stability, housing, employment and social network (otherwise known as Social Determinants of Health), precisely the areas where many I/DD organizations have expertise and experience.



Compounding Social Determinants: The Opportunity...

- Leading health providers and payers are only beginning to grapple with social determinants as the critical element of value-based success
- Roughly 80% of “health outcomes” are derived from issues and settings outside traditional “control”
- These big players will depend on allied organizations to be successful for their populations and their risk



Step #1, Q1: What do we see as the key behaviors or services that we provide that summarize or reflect our “value”?

Helping people find voice and make choices
Material needs are met
High quality of life
People are safe
Community activities and employment
Dignity

1

Whole-person health approach
Safety-net
Deep rich relationships with people served
Family + individuals
Medical outcomes – keep people healthy
More holistic perspective
Wraparound, robust service delivery model

Value varies depending on the perspective –
difference among payers, entities, people
receiving supports and families

3

Formal and informal care coordination
Trusted relationships
Ability to understand communication
Access to health and wellness supports
Vast array of services
Relationships with non-paid persons
Managing risk
Intimately know people throughout live
Community connections

4



Key Themes in Defining Quality for I/DD Services

- Informed Choice
- Person-Centered Practice
- Meaningful Goals
- Community Living
- Meaningful Days
- Relationships
- Dignity and Respect
- Embracing Technology



Building a Quality Framework

- Creating Quality Standards
 - Data
 - Measures
- Establish Common Language, Definitions, Understanding
- Culture Shift
 - CBOs
 - MCOs
- Investment in Quality



Demonstrating Tangible Value

- When organizations respected people's concerns and responded accordingly, agencies had significantly lower **hospitalization rates** (2.57 hospitalizations per person over a 3-year period versus only 1.03 over a 3-year period)
- When organizations put systems in place to ensure people had meaningful work and activity choices (when they had a meaningful day) **hospitalization rates** were significantly lower, at .65 per person supported over the 3-year period vs 1.74 per person supported when they didn't have systems in place to promote meaningful days
- When organizations had policies and practices in place to facilitate and maintain natural support systems, there were almost 2/3rds fewer **hospitalizations**
- When organizations had individualized emergency plans in place, the **hospitalization rate** was cut in half

What's Next



BUILDING THE FRAMEWORK FOR IDD QUALITY MEASURES



www.c-q-l.org/MMCreport

Friedman, C. (2018). Building The Framework For IDD Quality Measures. Towson, Chicago, Omaha: CQL | The Council on Quality and Leadership, the Institute for Public Policy for People with Disabilities, and Mosaic.

Integrating Value-Based Payment, Quality Measurement & Outcomes

Value-Based Payment, Quality Measurement & Outcomes



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- What methodologies could you explore?
- What services would you include in a VBP arrangement?
- What measures would you use or need for your VBP proposal?

Outcomes & Data Crosswalk:

Community Integration – how do we demonstrate that we have increased the number? Length of time? Interaction w other people? Consider state's HCBS transition plans? Setting size?
**what is quality to the person? How do they define it?

Social Role, social capital – how are these measured??
Is someone doing what they want to do? **PERSONAL CHOICE and Person-centered Plan**

Organization has an evidenced-based planning process

National Core Indicators? States identify a few key indicators?

What does the payer do to make this better? We need to create something that's measurable...

MO – community integration – individuals are known in their community, in the places where you run your errands, **"Becoming a Regular"**. These specifics lend themselves to being measured.

Evaluate the language we use and push ourselves to make appropriate changes

Simplify, Simplify, Simplify

Challenging to support personal choice when there is such a strong regulatory environment hyper focused on health and safety with the federal administration.

Outcomes, Service and Data Cross-Walk



POTENTIAL PAYER NEEDS OR OUTCOMES	CBO SERVICE	SERVICE IMPACT	WHAT IS THE EVIDENCE? WHERE IS THE DATA?
Consumer satisfaction			
Consumer engagement			
Community integration			
Employment placements			
Improved length of employment			
Improved health			
Reduced hospitalizations or nursing facility stays			
Reduced emergency room visits			
Reduced health and safety incidents			
Cost savings			
Improved ability to keep appointments			
Prompt initiation of services			
Improved performance on quality measures (e.g. NCI, NCI-AD, HEDIS)			
Improvements to Social Determinants of Health (SDoH)			

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Lunch

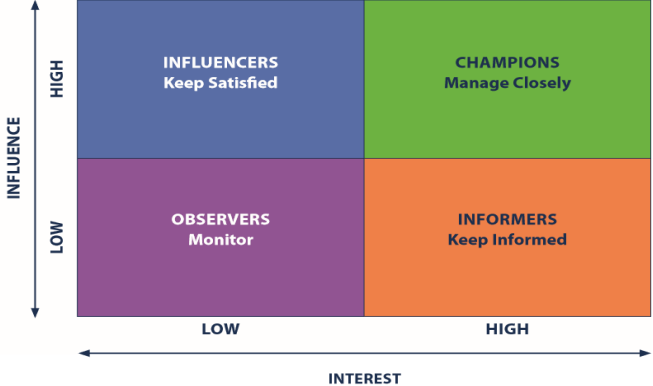
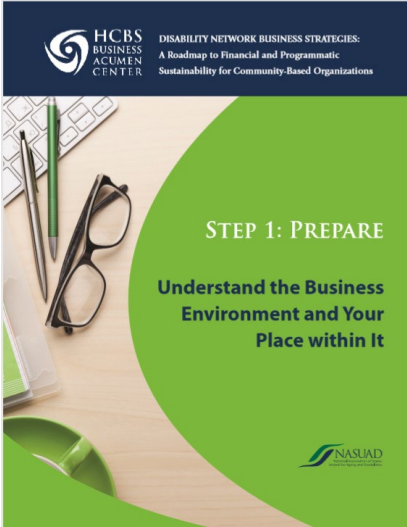
See you back at 1:15 pm!

Toolkit Review

Step 1: Prepare

Vision
Mission
& Values

Strengths
Weaknesses
Opportunities
Threats



Step 2: Plan



Step 3: Stabilize



Step 4: Grow and Develop



Step 5: Monitor, Evaluate and Respond



Toolkit Refinement



131

- With your experiences to date, where can we include more resources or tools
 - ▣ Templates
 - ▣ Examples
 - ▣ Clarification

Wrap-Up: Day 2

Wrap-Up Day 2



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- Business Acumen & Business Development Learning Collaboratives - Day Four
 - Thursday, August 29th from 8:30 am – 9:45 am in Heron

DAY 2: BUSINESS DEVELOPMENT LEARNING COLLABORATIVE

Tuesday, August 27, 2019

Day 2:

Today's Agenda - Business Development



135

- Business Stability & Infrastructure
- Business Growth & Development
- Erica Lindquist – Review of Module 3
- Negotiations & Contracts



Organizational Stability & Infrastructure



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■ Workforce

- What is your Value Proposition as an employer?
 - ACTIVITY – Draft your Employer VP

- Recruitment ~ Hiring and Onboarding

- Retention ~ Cultivating Engagement

Organizational Stability & Infrastructure



137

■ Financial Management

- Know your numbers – data

- Understanding which numbers tell the most accurate story
 - Lag versus Lead Indicators

- Feeling the Numbers, Chip Dodd, SSVA and BDLC member

Organizational Growth & Development



138

■ Payer Relationships

- Focus on the payers, their future plans, and your competitors for consumer services in those systems (Open Minds, 2013)
 - Step #1: Market mapping
 - Step #2: Solution-focused sales and payer strategy (playbook) development
 - Step #3: Developing a service with the payer value proposition in mind
 - Step #4: Concept sale, program development, and contracting
 - Step #5: Consumer pull through
 - Step #6: Managing to the performance metrics

Organizational Growth & Development



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■ Partner Relationships (Forbes, 2013)

- The first step to building a strategic partnership is to identify which types of partners can help you achieve key goals (e.g., get more customers, lower service costs, etc.) and/or otherwise give you competitive advantage.
- Then, start reaching out to these firms. While it will take time, once you secure these partnerships, your business' revenues and profits can start to grow. And, if you make these partnerships exclusive, you can gain critical competitive advantage.

Understanding your Costs

Critical Ratios	Number of <u>DSPs</u>	Number of DSP Labor <u>Hours</u>	Total <u>Dollars</u> paid to DSPs
Number of <u>Customers</u>	Staff to Customer Ratio	Number of DSP hours per Customer	Labor cost per Customer
Number of <u>hours</u> Customers are Supported	Customer Support hours per DSP	Labor Hours Percentage	Labor Cost per Hour of Support
Total Customer Billing <u>Dollars</u>	Customer Billing per DSP	Income per hour Worked	Labor Dollars Percentage

Wrap-Up Day



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- Business Development Learning Collaborative Day Three
 - Wednesday, August 28th from 2:45 pm – 5:30 pm in Suite Heron

DAY 3: BUSINESS DEVELOPMENT LEARNING COLLABORATIVE

Wednesday, August 28, 2019

Day 3:

Today's Agenda - Business Development



- Financial Monitoring
 - ▣ Tom Lindquist, Allina Health | Aetna

- Module 3
 - ▣ Sage Squirrel

- Module 4
 - ▣ Sage Squirrel

- Module 5
 - ▣ Erica Lindquist, NASUAD

Value Based Purchasing: The Payer Perspective

Tom Lindquist, CEO

Allina Health | Aetna



Allina Health | Aetna

Tom Lindquist

What we'll talk about today

Transforming the healthcare system

Provider Collaboration - lower costs and better outcomes

Delivering Results – Program Consideration



Terms you may hear

ACO
Accountable Care
Organization

A strong form of VBC that includes a group of providers, who come together voluntarily to give coordinated high quality care to their patients. ACS can help these groups accelerate their move up the value continuum.

VBC
Value Based Contract
(also Value Based Care)

Network arrangements with providers where payment considers value provided (e.g., quality, efficiency) rather than just payment of a fee for each service the provider performs.

A photograph of a modern cable-stayed bridge at night, viewed from a low angle looking down the length of the bridge. The bridge's structure is illuminated, with light reflecting off the cables and the deck. The sky is dark, and the overall image has a blue and green color overlay. The text "Transforming the Healthcare System" is centered in white.

Transforming the Healthcare System

What if we created a system that works better for everyone?



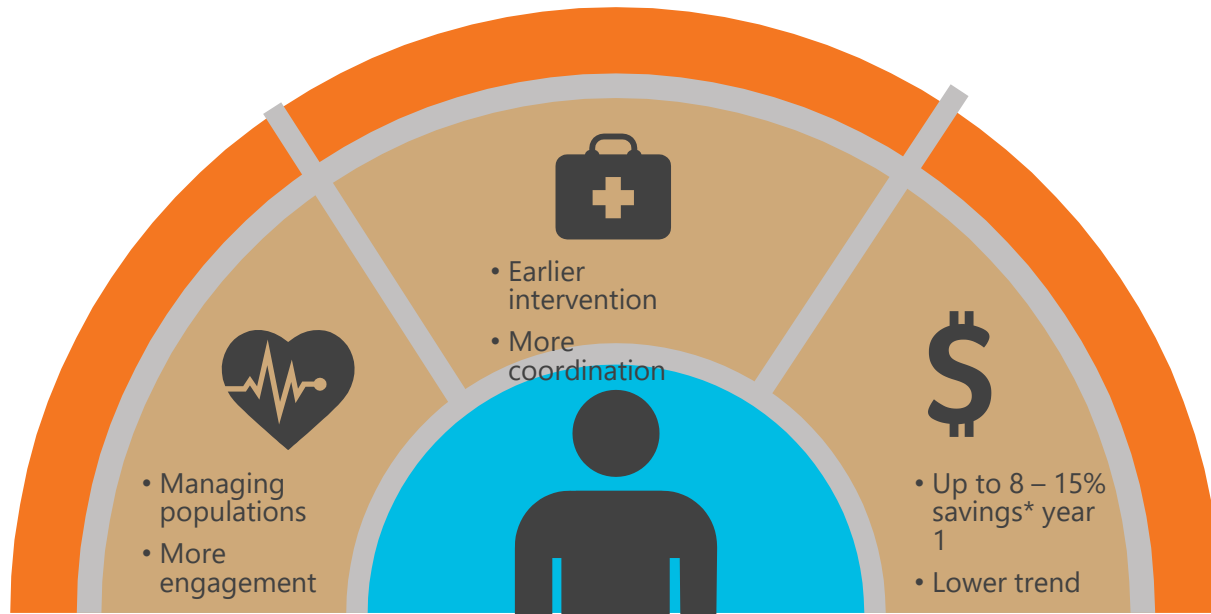
- **Episodic treatment** of the sick
- **Rising costs** and transactional care
- **Independent** and detached providers
- **Outdated** technology and communication
- **Frustrating** and time consuming patient experience



- **Holistic care** for the entire population
- **Shared accountability** to improve outcomes and lower costs
- **Transparent** and engaged providers
- **New tools and services** to make it easier
- **More productive** and satisfied employees

Our vision of transformation

Building a healthier world by paying for **value** not volume

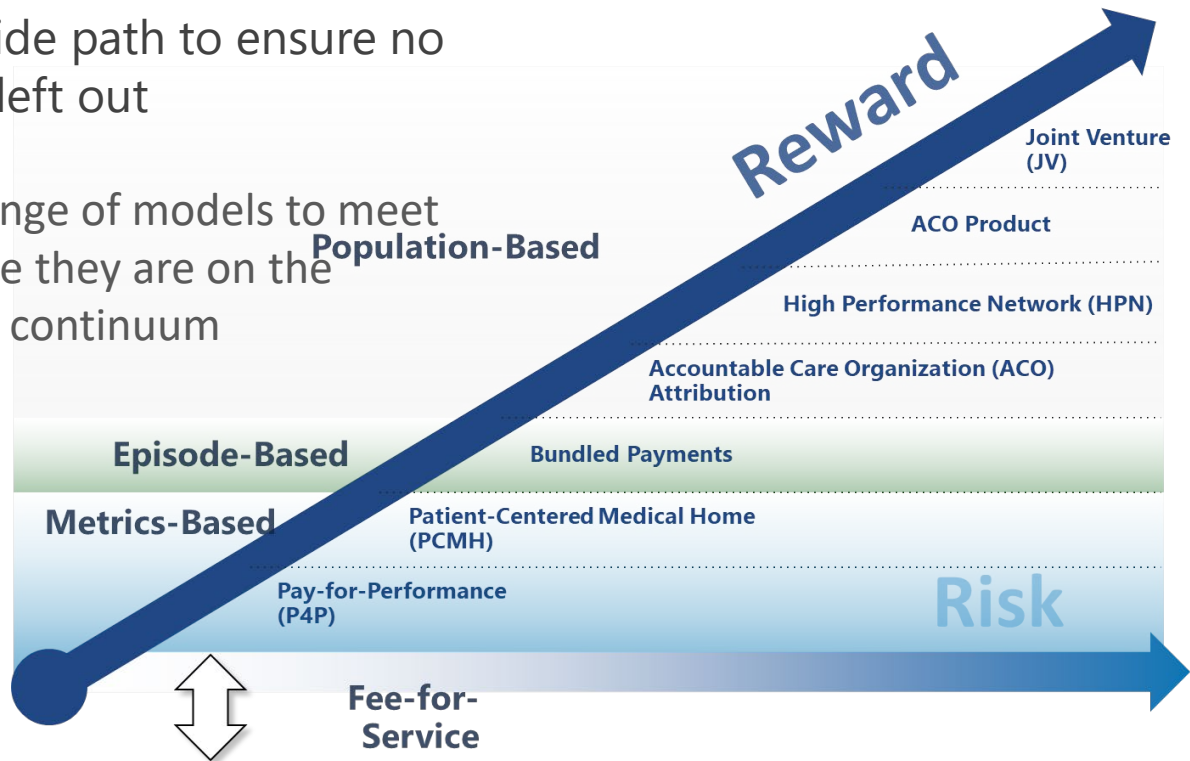


*Actual results may vary since they depend on a variety of factors including ACO plan model.

Value-driven options

Including a glide path to ensure no providers are left out

We deploy a range of models to meet providers where they are on the transformation continuum



Collaboration creates more value



Providers

Focus on those who need them most:

- One-on-one patient engagement
- Clinical credibility



Together

WE FIND AND ENGAGE MORE

patients with Aetna technology plus provider records

WE HELP MORE

members have a streamlined experience

WE SAVE MORE

with efficient care across the entire care team



Allina Health Aetna

Information on all patients and resources to support between visits:

- Data analytics
- Leading technology
- Care management programs

We're changing how health care is delivered... and already seeing great results



Sources, all ACOs:

¹"Payer-Provider Collaboration in Accountable Care Reduced Use and Improved Quality in Maine Medicare Advantage Plan," Aetna and NovaHealth, Health Affairs, Volume 31, Number 9, September 2012. ²Aetna-Carilion ACO, Modern Health Care, December 17, 2013. ³Aetna ACS Analytics, for the year 2013.



Provider Collaboration

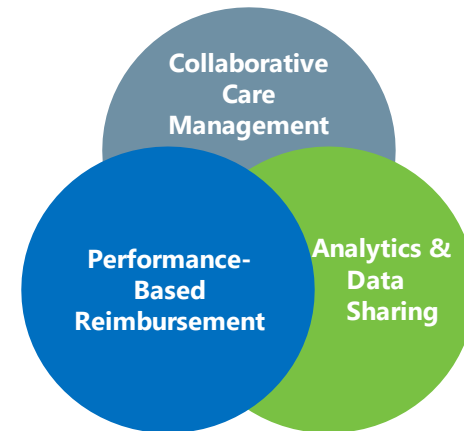
lower costs and better outcomes

Provider collaboration initiative

Three main components to collaboration

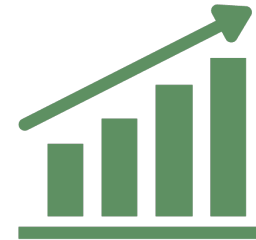
Collaborative care management: Provide care management resources to collaborate with physicians and assist in coordinating care for members.

- **Performance-based reimbursement:** Metrics and incentives are designed to encourage adoption of practices that:
 - Proactively identify and manage chronically ill patients
 - Improve clinical effectiveness,
 - Reduce avoidable utilization
 - Deliver improved care
- **Analytics and data sharing:** Provide actionable member-level reporting and promote exchange of health information to facilitate identification of member needs and follow-up care.



Improvement with DRIVE

It's all about getting better and doing it together



Collaboration Continuous improvement

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D

Determine current position in areas like Stars, Inpatient Admissions and Clinical Utilization.

R

Rank performance against previous years and against like-provider groups. Is there room for improvement?

(DRIVE)

I

Identify a goal. It allows us to work towards something to be successful. Without it, we have no direction.

V

Value goal. If inpatient admissions is improved by 5%, how does that impact overall performance?

Success

E

Execute the action plan needed to reach the goal. Then, review if it impacted performance and repeat the process.

Comparison of value-based care models

Reimbursement Models

	Pay-for-Performance (P4P)	Patient Centered Medical Home (PCMH)	Accountable Care Organization (ACO) Attribution
	<p>A first step into value-based contracting:</p> <p>Payment shifted from Fee-for-Service (FFS) to incentives for meeting quality goals</p>	<p>Primary care model:</p> <ul style="list-style-type: none"> Coordinate care for patients, using team-based care and the EHR Enhance care with Aetna care management programs 	<p>Population health model:</p> <ul style="list-style-type: none"> Manages all care for attributed members, using team-based care and the EHR Enhanced collaboration with Aetna care management programs
Financial Opportunity	Shift portion of payment from FFS to incentives for improvement quality measures	Attribution-based ACP payments and incentives for quality and efficiency improvements	Shift portion of reimbursement from FFS to ACP payments and incentives tied to quality and cost of care improvements, with risk for poor performance
Applicability		Qualified medical home practices and/or clinically integrated networks (CINs)	Health systems/ integrated delivery systems (IDS), clinically integrated networks (CINs) and large primary care systems



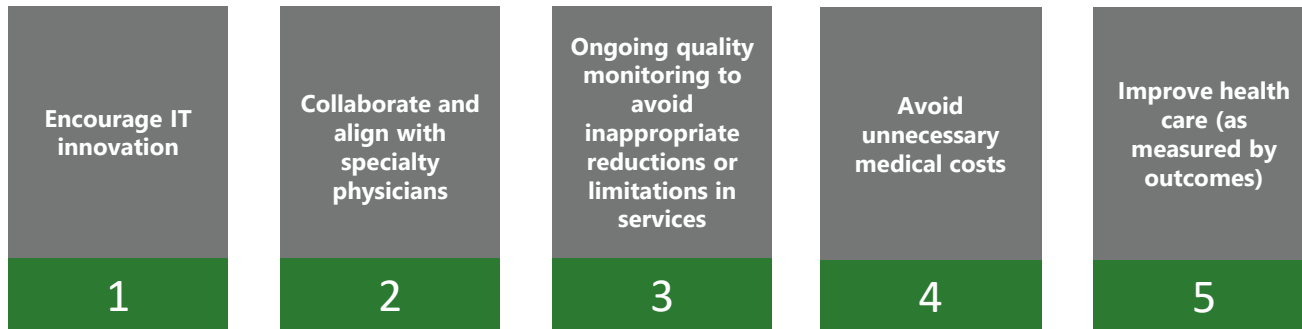
Delivering Results – Program Consideration

Goals and strategies

There are three primary goals:

1. Improve the patient experience
2. Improve quality
3. Lower the cost of health care and frequency of unnecessary treatments/services

Strategies employed in our P4P programs provide several benefits



Provider pay-for-performance program – targets and scores

Targets

A target provides a clear, simple, direct standard of expected performance. We use targets to give direction to a primary care doctor or group/practice on their performance for each upcoming contract year.

- Target setting will be discussed and agreed upon during negotiations using a preview scorecard. A primary care doctor or group/practice could fall below, hit, improve or exceed agreed-upon targets.
- Final targets will be published in *an agreed-upon scorecard*. During the negotiation process, the preview scorecard will contain default rates for each measure. These default rates are estimates. They are based on known national, regional or market averages or reasonable expected performance.

For example, the target for the Formulary compliance measure could be, if greater than 90 percent then maintain score 90 percent or higher; if less than the national average increase score to the national average.

Scores

Scores represent a doctor's or group's/practice's performance on each measure. They will be recorded as percentages. A score value will be assigned to each measure.

- A minimum volume requirement for each measure to be included on the scorecard has been established.

For example, the denominator for the 30-day readmission rate measure requires at least fifty (50) records to be activated as a measure. By contrast, the denominator for the adoption of medication e-prescribing measure requires only one (1) observation.

- All the categories with measures meeting minimum volume requirements will be considered and their weighting aggregated for a score at the end of the scorecard. The scorecard will dictate the payment.
- The total maximum score that can be achieved as a composite or final score on a scorecard will be 100 percent.

Translating scores to incentive payment

Aetna's P4P model supports an incentive payment based on targets achieved after the measurement/performance period. The payment methods are a one-time lump sum payment or an increase in rates.

Rate increases relative to performance

A portion or all of the negotiated increase is dependent on maintenance of or improvement on agreed targets.

Aetna's scorecards offer one aggregate score that is based on the weighted results of each section. Its called the Total Score and it's presented as a percent.

General guidelines for payment distribution are:

A 50 percent minimum Total Score must first be achieved to be eligible for an incentive payment.

- Payouts are calibrated as follows:
 - 50 percent to 69 percent = 50 percent of the negotiated payment
 - 70 percent to 89 percent = 75 percent of the negotiated payment
 - 90 percent or more = 100 percent of the negotiated payment

For example, a Total Score of 82 percent of the on the scorecard, results in an eligibility of 75 percent of the negotiated payment.

Provider pay-for-performance program – contract considerations

This performance program is intended to:

- Create a path towards high performers
- Provide a starting point for continued discussions and exploration of cost and quality improvement opportunities
- Provide baseline performance results
- Provide benchmark performance against local, regional and national benchmark
- Provide feedback for improvement or maintenance of performance against measures
- Introduce data sharing to help improve physician performance
- Better align payment to performance

This performance program is not intended to:

- Increase medical costs with correlated performance levels
- Guarantee fee-for-service rate increases
- Initiate unscheduled rate negotiation

An aerial photograph of a wide river flowing through a city. A dam is visible in the middle ground, with a small boat docked nearby. The riverbanks are lined with dense green trees. In the background, a city skyline is visible under a cloudy sky. The entire image has a green color overlay.

Questions

Module Review

Yonda Snyder, Sage Squirrel

Erica Lindquist, ADvancing States

Donna Martin, ANCOR

Step 3: Stabilize



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- Human Resources
- Business Processes
- Financial Management

Step 4: Grow and Develop



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- Understand Your Payers and Partners
- Understand Reimbursement Methodologies
- Price Your Services
- Develop Your Value Proposition
- Marketing and Outreach
- Execute an Agreement

Step 5: Monitor, Evaluate and Respond



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- Measurement
- Finances
- Compliance
- Quality
- Continuous Quality Improvement
- Culture

Wrap-Up Day 3



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- Business Acumen & Business Development Learning Collaboratives - Day Four
 - Thursday, August 29th from 8:30 am – 9:45 am in Heron

DAY 4: BUSINESS ACUMEN & BUSINESS DEVELOPMENT LEARNING COLLABORATIVES

Thursday, August 29, 2019

Day 4:

Today's Agenda - Business Acumen & Business Development



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- The Essential Role of CBOs in Integrated Care
 - ▣ Donna Martin

- What Health Plans, Hospitals, and Integrated Care Organizations Need to Know about You
 - ▣ Erica Lindquist

- Next Steps & Keeping the work moving forward



“The Essential Role of CBOs in an Integrated Care Program”



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■ By the 2018 Numbers

- 22 states w MLTSS programs
 - 6 of those state include I/DD services
 - 3 of those do so under separate authority
 - 1 state has MLTSS for I/DD only
 - 1 state is a bit of a hodgepodge
 - 2 states are All IN

The Essential Role of CBOs in an Integrated Care Program



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- Developed in 2018 and will publish as part of the grant's collateral
- Explores the history and expertise of CILs and I/DD providers
- The Essential Role
 - ▣ Disability and Local Expertise
 - ▣ Provision on non-medical supports & services
 - ▣ Supporting Successful Partnerships w States and MCOs

The Essential Role



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- Disability and Local Expertise
 - ▣ Long tenure and deep relationships in the community
 - ▣ Strong networks of allied services
 - ▣ Relationships w individuals and families
 - ▣ Focused on quality
 - ▣ Opportunity for partnership with MCOs for value-added activities
- Provision on non-medical supports & services
- Supporting Successful Partnerships w States and MCOs

The Essential Role



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- Provision on non-medical supports & services
 - ▣ Intersection with SDH
 - ▣ Focus on delivering a social and environmental model of support
 - ▣ Opportunity to integrate health-care oriented service through a “disability lens”

- Supporting Successful Partnerships w States and MCOs

The Essential Role



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- Supporting Successful Partnerships w States and MCOs
 - ▣ States' Role
 - Engage CBOs' early in the development of a MC program
 - Support CBOs' need for technology and compatible business systems
 - Development of Beneficiary Support Systems
 - ▣ MCOs' Role
 - Early outreach to CBOs
 - Support in transition, system dev and claims management

What Health Plans, Hospitals, and Integrated Care Entities Need to Know about You

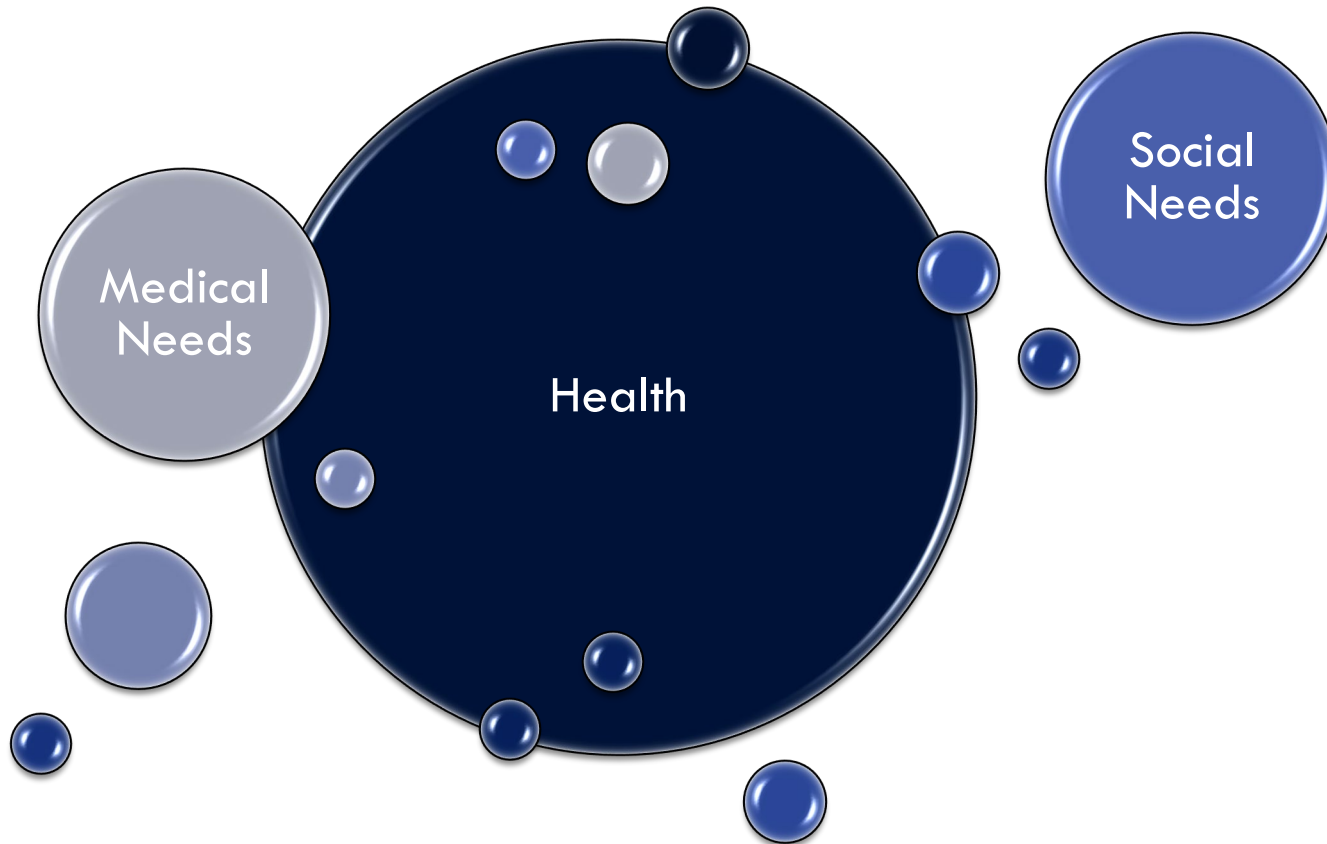


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■ Tool for CBOs

- used to prepare for meetings with Health Plans, Hospitals, and Integrated Care Entities.

Medical and Social Connection



Models are different

The Medical Model of Disability



This is a diagram of the traditional Medical Model of Disability, which the Social Model was developed to challenge.

The Social Model of Disability



The Social Model of Disability states that the oppression and exclusion people with impairments face is caused by the way society is run and organised.

Know You Offer Value

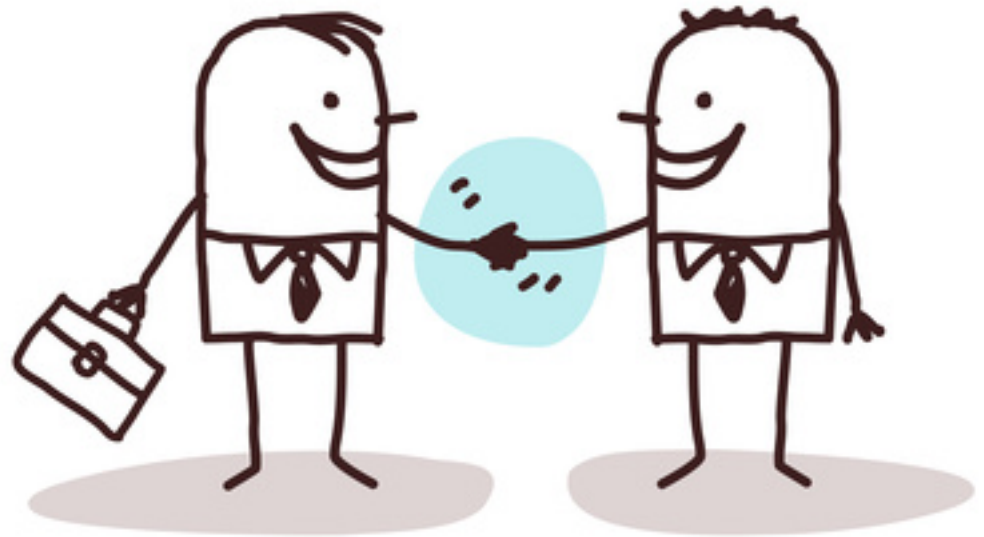


180

- ...but may have a hard time proving it
- National Core Indicators (NCI) and National Core Indicators – Aging and Disabilities (NCI-AD)
- Evidence based practices in many areas
- Much anecdotal data – building data collection systems
- Want to know what outcomes measures MCOs will be expecting or collecting from them

Partnering

- You want to work with them
- You want to be a part of the conversation
- You want to collaborate



Building takes time

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- Small margins
- Mission-driven
- Committed individuals



Nationally, CBOs tell us...



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- To engage in partnerships with MCOs, CBOs need to know how to...
 - ▣ articulate their value proposition
 - ▣ identify who to connect with
 - ▣ market their services
 - ▣ price their services
 - ▣ meet contract expectations

Closing



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- Lessons learned - What other stories need to be shared?
- What will you do beyond the learning collaborative?
- Toolkit review and finalization



For more information, please visit: www.hcbsbusinessacumen.org

E-mail: businessacumen@nasuad.org

Or Call: 202.898.2583