February 6, 2017

Enhancing Response, Capabilities, and Opportunities from Network Participation

What do we do now?

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Today's Discussion

- Impact of the new administration:
  - What do we know?
  - What changes?
- The Primary Care Value Equation
- Payment Methodologies
- Skills for Networks
- Questions and Answers

WELCOME AND INTRODUCTIONS

… Who We Are

Starling Advisors works nationally with Safety Net Providers, with a specific focus on Health Centers, Networks of Health Centers, Primary Care Associations, and the National Association of Community Health Centers to answer the question:

"What changes, if any, do we need to make to insure a role in providing high-quality, comprehensive primary care under Health Reform?"

SNAC National Safety Net Advancement Center — Partner To

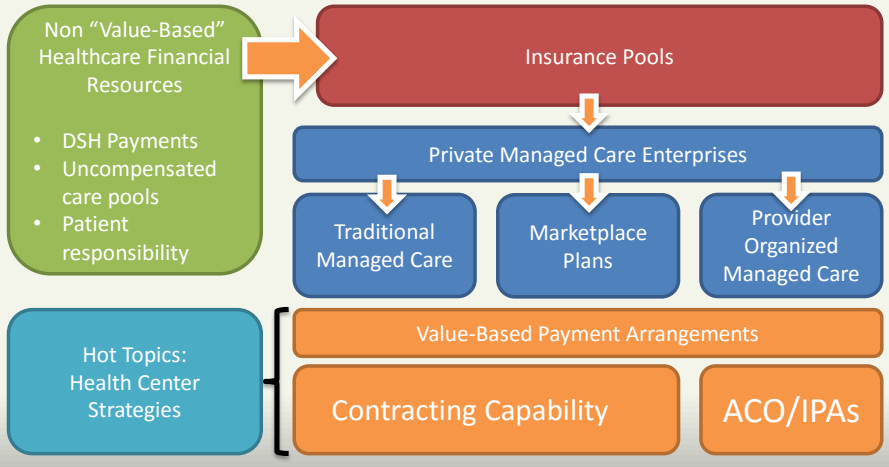
ASU School for the Science of Health Care Delivery, Arizona State University — Grantee

Robert Wood Johnson Foundation — Funded By

Health Reform in 2017

WHAT NOW?

ACA Reform: Simplified



What happens now?

ACA Component	Change	Impact on CHCs
Pre-existing conditions	Unlikely to change	Minimal
Coverage under parental insurance until 26	Unlikely to change	Minimal
Individual mandate	Likely eliminated	Minimal
Subsidies for low and medium income families	Phased out over time	Moderate
Marketplace	Insurers to sell across state lines	Moderate
Medicaid to 138%		

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Medicaid to 138%	Block Grants	Yuuuuge.

Ask yourself these questions…

- Do you expect more or less of Medicaid and Medicare expenditure under private insurance methods?
- Do you anticipate more or fewer insurance plans to interact with?
- Do you expect more or less pressure to manage cost, quality, and patient experience?

VALUE – STILL THE KEY TO SUCCESS

What is Value?

$$\textbf{Value} = \left\{ \frac{\text{Outcome}}{\text{Cost}^{(us)} + \text{Cost}^{(them)}} \right\} \times \text{Risk} \times \text{Scale}$$

- **Value.** Quantifiable, monetary benefit your care provides to a payer's patients.

What is Value?

$$\text{Value} = \left\{ \frac{\textbf{Outcome}}{\text{Cost}^{(us)} + \text{Cost}^{(them)}} \right\} \times \text{Risk} \times \text{Scale}$$

- **Outcomes.** Measurable indicators of population health which demonstrate effectiveness of your care model.

What is Value?

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- **Cost(us).** The cost of the care you deliver to patients, and the relative efficiency of this care. For example, keeping a population of patients with diabetes healthy using less visits and more telephonic follow up will be considered more efficient than using more visits.

What is Value?

$$\text{Value} = \left\{ \frac{\text{Outcome}}{\text{Cost}^{(us)} + \text{Cost}^{(them)}} \right\} \times \text{Risk} \times \text{Scale}$$

- **Cost$^{(them)}$.** The cost of the care provided to your patients that is delivered outside of your organization. Also referred to as cost effectiveness. When a population of patients uses less inpatient days than projected, the cost effectiveness of your care is considered to be higher.

What is Value?

$$\text{Value} = \left\{ \frac{\text{Outcome}}{\text{Cost}^{(us)} + \text{Cost}^{(them)}} \right\} \times \textbf{Risk} \times \text{Scale}$$

- **Risk.** A measure of the impact of certain factors on cost of care. For example, a population with high incidence of chronic disease has more underlying risk than a population of patients with no chronic diseases. Your value is impacted by your ability to identify and address these risk factors.

What is Value?

$$\text{Value} = \left\{ \frac{\text{Outcome}}{\text{Cost}^{(us)} + \text{Cost}^{(them)}} \right\} \times \text{Risk} \times \textbf{Scale}$$

- **Scale.** Your ability to deliver a consistent care model to a large, and increasing population of patients. Scale also includes the concept of access, which is the ability to deliver care in a timely fashion without unnecessary delays.

What can you do alone?

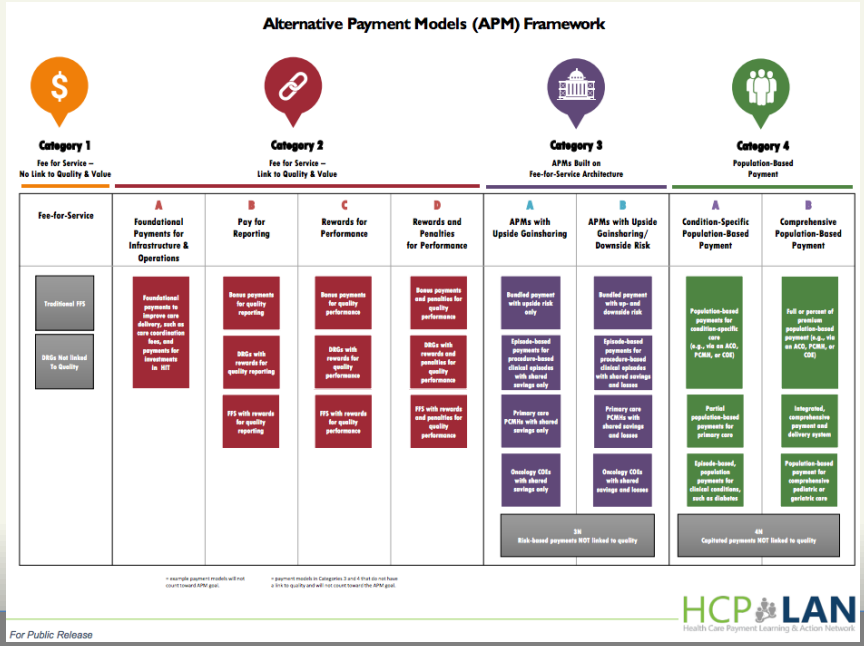
$$\text{Value} = \left\{\frac{\text{Quality}}{\text{Costs}}\right\} \times \text{Risk} \times \text{Scale}$$

1. **Contract for value**
2. **Maximize existing contracts**
3. Benchmark quality
4. Embed QI into care teams
5. Evaluate total medical expense
6. **Outsource underperforming non-strategic functions**
7. **Insource strategic medical functions**
8. **Implement ICD-10 properly**
9. Develop risk adjustment tools for use by CHCs
10. Conduct health screenings
11. **Implement variable compensation strategies**
12. Leverage PCMH for enhanced access
13. **Capacity planning**
14. Brand and market

PAYMENT METHODOLOGY

Range of Payment Methodologies

- Market forces will push away from FFS payment methodologies.
- Integrated networks play three key roles:
  - Make providers eligible for payment methodologies.
  - Create leverage to push back against too much risk, too fast.
  - Serve a key role in managing the risk / reward profile of various payment methodologies.
- Few Health Centers have enough patients to do this alone.



SKILLS FOR NETWORKS

Clinical Integration

- It is our experience that networks that are financially successful are clinically integrated:
  - The network plays a role (or series of roles) that assist the participants in achieving the goals of a specific payment methodology.
  - This role becomes an essential part of managing the payment methodology.

What does integration look like?

Clinical Integration

Ultimately, Clinical Integration is about having a consistent care coordination / care management model:

1. Consistently applied evidence-based rules
2. Data to support decision-making
3. Discreetly assigned staff
4. Proactive outreach
5. Documentation standards
6. Outcome tracking

Clinical Integration: Different Philosophies

Must be Delivered at the Site of Care

- Direct clinical care
- Registration and billing

Can Be Administered at the Site or the Network

- Health IT
  - EHR
  - Population Health Management
- Care Coordinators
- Revenue Cycle Management
- Outreach and enrollment

Should be Administered by the Network

- Management of patient attribution data
- Plan credentialing
- Risk stratification
- Performance benchmarking

Skill 1: Attribution

- A Network must serve as the intermediary between the Payer and the Member in determining the assigned population of patients under a given payment methodology.
- All value-based payment methodologies require a defined population of attributed patients.
- This is best handled by the network because the network holds the value-based contract.

Skill 2: Plan Credentialing

- Plan credentialing is the process of articulating the precise makeup of the network to the payer.
- It involves enrolling billing numbers and other key information about the Members and their clinicians.
- It assists in billing, but its primary purpose is to support effective attribution and performance against the contract.

Skill 3: Risk Stratification

- Risk stratification is about using data to identify patients in the attributed population who would benefit from more intense care coordination.
- Patients at different levels of risk will have different evidence-based care coordination interventions (whether performed by network or local site of care.)

Skill 4: Performance Benchmarking

- The network should maintain the data infrastructure to continually evaluate performance:
  - Likelihood of achieving payment targets in value-based contract
  - Ability to provide participants with feedback and areas for improvement
  - Ability to hold participants accountable for their sub-populations

CONCLUSION

Conclusions

1. Value-based payments are here to stay and may accelerate given recent changes in our environment.
2. Clinically Integrated Networks are an important tool for managing value-based contracts.
3. Networks develop a care coordination or care management model that is applied consistently.
4. Some key services are provided by the network, others may be delegated back to the provider sites of care.
5. All of this is in support of better financial performance under changing expectations from payers.

Q&A