Enhancing Response, Capabilities, and Opportunities from Network Participation

Where do we go from here?

The Case for Value

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Today's Discussion

- A changing political landscape:
  - 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

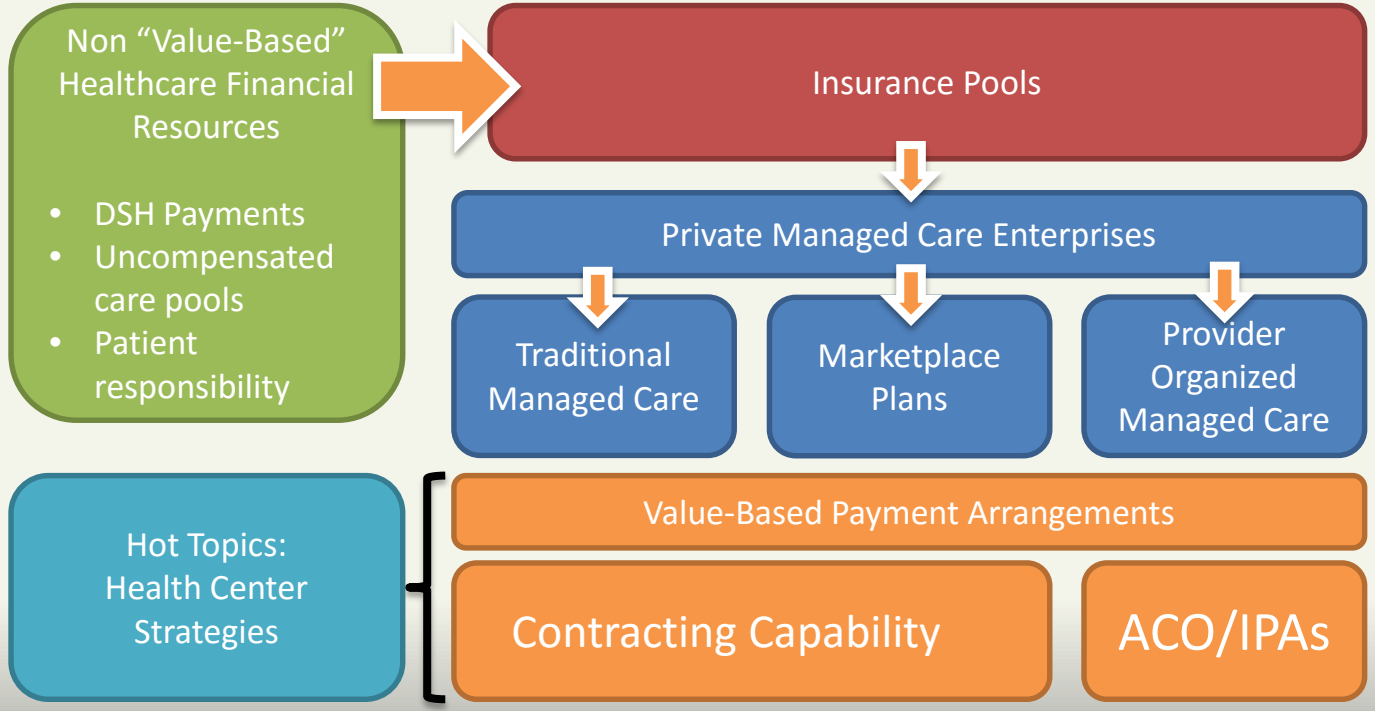
ASU School for the Science of Health Care Delivery, Arizona State University — Grantee

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%	Block Grants	Significant.

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?

In any repeal scenario…

- Expect more control at the state level.
- Assume that states that have not expanded may radically change their program.
- Expect “waiver-like” activities within most states.
- ***Prepare to be in a position to talk about value.***

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?

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

- **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?

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

- **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?

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

- **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?

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

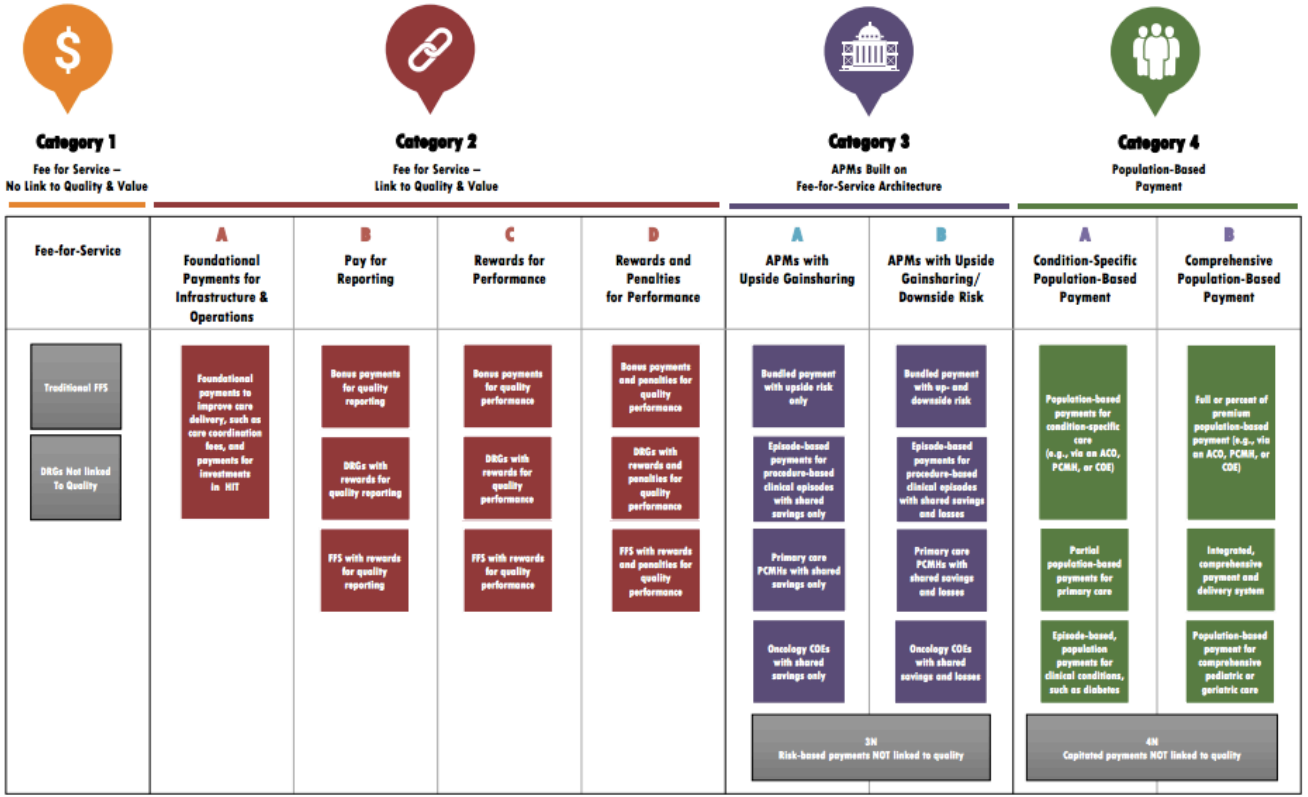
1. **Contract for value**
2. **Maximize existing contracts**
3. Benchmark quality
4. Embed QI into care teams
5. Evaluate total medical expense
6. **Outsource underperforming non-strategic functions**
7. **Insource strategic medical functions**
8. **Implement ICD-10 properly**
9. Develop risk adjustment 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.

Alternative Payment Models (APM) Framework



= example payment models will not count toward APM goal.

= payment models in Categories 3 and 4 that do not have a link to quality and will not count toward the APM goal.

HCP LAN
Health Care Payment Learning & Action Network

For Public Release

The importance of value in payment models

- All value based payment models expose us to evaluations of our performance (value.)
- The concept of “population health management” is the idea that we can apply systems of care an unknown population and get a consistent result.

SKILLS FOR POPULATION HEALTH

Population Health

Population Health Management is the combination of all available sources of data relevant to the health of a population for the purpose of analysis.

The analysis produces a prioritized list of actionable steps that can be taken by a coordinated team of caregivers to improve on the outcomes, cost, and care experience of the individual people making up that population.

What will population health management mean?

- Attributed Populations
- Risk Stratification
- Expanded Care Teams
- Non-Encounter Touches
- Data Aggregation
- Evidence Based Care
- Payment for Value

ACCOUNTABILITY

Skill 1: Attribution

- All value-based payment methodologies require a defined population of attributed patients.
  - This is more complicated that it sounds.
  - Different payers, different models, different impacts on outreach.
- We will need systems for tracking patients we have not yet met.
- We will need processes for activating patients to utilize our health centers.

Skill 2: 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 3: Expanded Care Teams

- Maximizing value cannot be done on the efforts of billable providers alone. For example:
  - Nursing/pharmacist follow up can dramatically reduce readmissions for CHF patients.
  - Community health workers can go into homes to assist patients in executing care models and assess risks.
  - Virtual specialty visits can enhance access to needed care.

Skill 4: Non-Traditional Touches

- The population health world is far less dependent on face to face encounters as the only way to provide care:
  - Virtual visits via video call / photos.
  - Remote monitoring devices that “listen” for changes in patient health status.
  - Basic telephone follow up.

Skill 5: The Data Infrastructure

- While still an emerging market, the CHC analytics space is coming into clearer focus:
  1. You must aggregated EHR data for analysis and reporting.
  2. Claims data becomes immensely important in managing utilization and evaluating risk.
  3. Admit, discharge, transfer data from facilities is critical to proactively intervening on patients' behalf.
  4. A system for tracking and reporting non-traditional touches is essential.

Skill 6: Evidence Based Care

- The technology will be used to drive evidence-based processes in ways that EHR alone have been unsuccessful:
  - Patients in a certain risk-tier will automatically have prompts and reminders set.
  - Post-discharge care will follow standard workflows to reduce readmission.
  - Systems will be used to enforce and evaluate adherence to the evidence.
  - Data will prove its efficacy.

Skill 7: Payment for Value

- The most basic: Care coordination payments (above PPS.)
- Common: Shared savings tied to medical loss (Medicare.)
- Emerging: Capitated PPS models.
- Future: Discreet bundles for specific diseases and incidents.

They all build off of the same infrastructure and skills.

CONCLUSION

Conclusions

1. Value-based payments are here to stay and may accelerate given recent changes in our environment.
2. There is clearly “noise” in the system, which creates an opportunity to regroup and catch up.
3. That said, once the plan is put in motion, expect things to move very quickly.
4. Health Centers should have formulated a plan for proving and enhancing value – if your state asks, be ready to answer!
5. All of this is in support of better financial performance under changing expectations from payers. The winners get more of the investment!

Q&A