Clinical Integration and the Transition to Alternative Payment Methodologies

Art Jones, MD
Principal, Health Management Associates
CMO, Medical Home Network

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GOALS FOR THE SESSION

+ This is an educational session designed to improve understanding of alternative payment methodologies and the organization of providers to successfully operate under those arrangements.

+ During this session we will:
  + Describe the CMS supported nomenclature used to categorize alternative payment methodologies (APMs)
  + Summarize current APM opportunities within Colorado Medicaid’s Accountable Care Collaborative Phase II
  + Discuss considerations in selecting an integrated delivery system to pursue value-based payment arrangements
FFS PAYMENT IS MADE WHETHER OR NOT THE SERVICE IS:

+ Clinically indicated
+ The highest value means of addressing a healthcare issue
+ Provided in a high-quality fashion
+ Coordinated with other providers across the continuum of care
+ Has the desired impact on the individual and community
## APM Framework Nomenclature

The framework situates existing and potential APMs into a series of categories.

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
<th>Category 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee for Service – No Link to Quality &amp; Value</td>
<td>Fee for Service – Link to Quality &amp; Value</td>
<td>APMs Built on Fee-for-Service Architecture</td>
<td>Population-Based Payment</td>
</tr>
</tbody>
</table>

### Category 1
- **A** Foundational Payments for Infrastructure & Operations
- **B** Pay for Reporting
- **C** Rewards for Performance
- **D** Rewards and Penalties for Performance

### Category 2

### Category 3
- **A** APMs with Upside Gainsharing
- **B** APMs with Upside Gainsharing/Downside Risk

### Category 4
- **A** Condition-Specific Population-Based Payment
- **B** Comprehensive Population-Based Payment
State Medicaid Agencies are Pursuing Similar Paths

- Reward patient-centered, high quality care
- Reward health plan and system performance
- Align payment and reforms with CMS
- Improve outcomes
- Drive standardization
- Increase sustainability of state health programs
- Achieve Triple Aim
Ultimate Objective is Improved Population Outcomes and Reduced Cost Trends using Categories 3 & 4 Payments
THE ONGOING EVOLUTION OF HIGH-VALUE PEDIATRICIANS

+ Change provider focus from simply service provision to client outcomes
+ Improve the delivery of evidence-based care
+ Support access to services in the most member-centric fashion
+ Expand the use of non-traditional workforce team members
+ Improve client safety
+ Reduce waste
+ Improve provider collaboration across the full continuum of care
+ Assume delegation of some care management tasks with improved patient engagement & outcomes
+ Effectively manage total cost of care
PRACTICE TRANSFORMATION AND PAYMENT REFORM ARE INTERDEPENDENT

Delivery System Transformation

Payment System Transformation

Practice Transformation

without a Supportive Payment Methodology

is not Sustainable
PAYMENT REFORM MODEL FOR PCPS

- CM fee
- PCMH
- P4P
- Shared savings
- Capitation for non-PCP services

Fee-for-service or primary care capitation
EXAMPLES OF PEDIATRIC OUTCOMES METRICS USED IN APMS

+ **Preventive measures**
  + Well child visits
  + Immunizations
  + Lead screening

+ **Disease management metrics**
  + Asthma controlled medication usage
  + ADHD management
  + Appropriate treatment of pharyngitis

+ **Efficiency metrics**
  + ED utilization rate
  + Generic dispensing rate
PAYMENT STOOLS NEED 3 BALANCED LEGS TO STAND

+ Contain a hybrid of several different payment methodologies to incentivize and tie together desired behaviors

+ The key components of VBP arrangements include:
  + Base Compensation Models
  + Fee-for-service
  + Partial capitation as Advanced PCMH
  + Up Front PMPM (Care Mgmt., Admin., Clinical Transformation)
  + Quality Incentive Payments
  + Global Payments/Budgets
    + Surplus-sharing
    + Potential for future risk-sharing/global capitation

Base Compensation Model

Quality Incentive Payments

Global Payments/Budgets

Quality Modifiers

Care Management Fee
What bundle of services are applicable to pediatrics, can I manage, and what do I want to be accountable for now versus over time?
CONTRACTING DECISION #2: DEGREE OF FINANCIAL ACCOUNTABILITY

- Provider Financial Risk
  - Cost-based Contract
  - Fee For Service
  - Pay for Performance (P4P)
  - Incentive Payments
  - Bundled Payments

- Provider Integration and Accountability
  - Performance-Based
  - Episodic
  - Accountable Care
    - Full Capitation
    - Partial Capitation
    - Shared Risk
    - Shared Savings

- Pay for Performance (P4P)
- Incentive Payments
- Bundled Payments
- Shared Savings
- Shared Risk
- Partial Capitation
- Full Capitation
THE QUESTIONS PEDIATRICIANS ARE ASKING

+ Can’t I just keep living on the first floor?
+ Can I wait for the elevator?
+ How badly can I get hurt if I fall climbing the stairs?
+ Is this the only set of stairs and if so, can I skip some steps?
+ Do I really have to make it to the top?
+ Should I hold someone’s hand on the way up and if so, who’s?
UNIQUE CHALLENGES FOR PEDIATRICIANS OPERATING UNDER APMS

+ Category 2-4: Many of the quality metrics related to improved management of chronic conditions are more applicable to the adult population.

+ Category 2: A lower portion of the pediatric population risk stratify to the high risk group for care management and those complex children concentrated among a relatively small subset of pediatric providers.

+ Category 3-4: Many of the major services for which there is an opportunity to reduce cost and create savings (hospitalization, institutional post-acute care, long term care services and supports) occur much less frequently among the pediatric population.

+ Integrated delivery systems: pressure to join an IDS that manage the full spectrum of populations can weaken the “pediatric voice” in decision-making.
+ Category 1
  + Health First Colorado will pay physical health providers fee-for-service

+ Category 2
  + Structural administrative PMPM fee (at least $2.00 PMPM)
  + $4 PMPM withhold for performance on 7 Key Performance Indicators (KPIs)
  + Behavioral Health Incentive Program (5% BH capitation amount, 5 metrics)

+ Category 3
  + Shared savings performance pool (Regions 2,3,4,6,7)

+ Category 4
  + Capitated behavioral health benefit
  + Region 1 and 5 also have capitated models for physical health
Integrated Delivery Systems:
Driving Delivery System Transformation & Population Health Outcomes

• Aligning multiple stakeholder organizations and providing the infrastructure to achieve better population health outcomes

**Organizational Structure**
- Shared vision held by diverse providers
- Egalitarian governance and collaborative decision-making
- Contract with a publicly-owned Medicaid MCO for 120,000 patients
- Multiple stakeholder accountability for driving outcomes

**Practice Transformation**
- Care coordinators hired by and "embedded" in each provider setting
- Team-based model
- Standardized workflows across multiple providers
- Redefinition of care to include social risk factors
- Complex care coordination capacity
- Model & technology to increase access

**Workforce Development**
- Training for care coordinators to implement the MHN model of care in an informed and standard way
- Certification for successful completion and demonstration of competencies
- Creation of pipeline of trained coordinators to work in low income communities

**Communication & Connectivity**
- Real time utilization alerts
- Information exchange with non-acute settings
- Platform for standardization of workflows
- eConsult with specialists to help primary care providers and their teams address medically complex populations

**Data Aggregation, Analytics & Reporting**
- Risk stratification, and predictive analytics to identify rising risk
- Timely and actionable patient information, integrating the patient’s risk profile, history, care plan, management strategy and workflows, real time utilization data and claims history
- Advanced analytics to support population health management

**Patient Engagement**
- Initial health risk assessment by nimble, embedded care coordinators
- Follow up response to alerts of emergency department use and hospitalization including for behavioral health concerns
- Distribution of shared savings to reward processes, outcomes and program implementation
- Financing of care coordination at the practice level
- Aligned financial incentives to drive outcomes
- Re-investment of savings into the delivery system

**Value-based Payment**
- Aligned financial incentives to drive outcomes
- Re-investment of savings into the delivery system

A scalable and replicable approach to population health & value based care

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MHN ACO Clinical Integration Committee

- CMOs, Provider Champions, Care Management Leads
- Physician led Subcommittees and Workgroups
  - ED Utilization
  - Transitions of Care
  - Behavioral Health Initiatives
  - Asthma
  - Quality Operations
  - Complex Care
  - Data and Program Evaluation
- Clinical Integration Dashboard
Subcommittee’s charge

Charge Overview

• Monitor utilization across the ACO

• Establish a standing set of reports and metrics across the ACO and at the level of the medical home

• Complete literature reviews to identify best practices and to inform the identification of metrics and benchmarks/goals

• Analyze results
  • Identify trends across the ACO
  • Identify opportunities for improvement such as:

• Formulate/present findings and recommendations to Clinical Committee
  • ACO overall and specific medical homes
  • Response to trends/opportunities for improvement
MHNConnect: Data Liquidity Driving Intelligent Care Coordination
MHN DISTRIBUTION OF SHARED SAVINGS: Enabling Collaborative Delivery Redesign

**Earned Savings Distribution**
- Surplus
- Deficit
- MHN ACO X%
- $0 Payout

**Surplus Distribution**
- 60%

**Risk Reserves**
- 25%

**Clinical Initiatives Investment**
- 15%

**Medical Homes/PCP Sites**
- 50% of Pool Funding
- Measures
  - 30 Day All Cause Readmissions *
  - % 7 Day PCP Visit - IP Discharge
  - % 7 Day PCP Follow-Up - ER Admissions
  - % CTM3 Compliance Survey Completion
  - % New Patient Visits within 90 Days
  - % Care Plans with timely updates
  - % PHQ-2 positives with a completed PHQ-9
  - ED Utilization per 1000 (FHP only) *

**Specialists & Hospitals**
- 50% of Pool Funding
- Measures
  - 7 Day All Cause Readmissions *
  - % Repeat ED visits w/in 30 days *
  - CTM3 Score (Value)
  - 95% System Uptime for HL7/ADT in MHNCnx Portal
  - % Reduction of 24 Hour Admits *
  - % Specialist Visits at ACO Hospital Providers

**Supports:**
- Practice Transformation
- Collaborative Care Model

**At Risk P4P**

**Care Management PPM**
- Complex Care Management
- Care Management Capitation
- Negotiable & Evolutionary

**Medical Cost of Care MLR < Contract MLR**

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PARAMETERS FOR CHOOSING AN INTEGRATED DELIVERY SYSTEM

+ Provider partners are like-minded in terms of missions and value
+ Partners are committed to pursuing VBP with a compatible risk appetite
+ Provider network can manage the full continuum of care across the targeted service area
+ Number of attributed lives by plan product are adequate for APM contracting
+ Membership/ownership fees are affordable and commensurate with anticipated ROI
PARAMETERS FOR CHOOSING AN INTEGRATED DELIVERY SYSTEM

+ Currently has or has the ability to create reserves to underwrite required infrastructure and to assume desired risk

+ Management is capable but affordable

+ IDS has a sound and progressive contracting strategy

+ The governance structure allows providers (including primary care pediatricians) an appropriate voice in decision-making

+ Reserved rights by ownership share are clear and acceptable
PARAMETERS FOR CHOOSING AN INTEGRATED DELIVERY SYSTEM

+ IT capabilities adequate in terms of connectivity, importing multiple data sources, analytics and timely population and patient-specific reporting
+ Well thought out plan for clinical innovations
+ Structured approach to care management
+ Outcomes dashboard including benchmarks
+ Demonstrable outcomes-oriented performance
+ Methodology for distributing savings is fair and incentivizes performance across the network
Developing trust, common purpose and accountability

Consensus on a model of care with a ROI

Assignment of care management responsibilities

Real time connectivity across the full continuum of care

Agreement on value-based metrics and targets

Reward structure commensurate to contribution in generating payer-incentivized outcomes

**CHALLENGES TO CLINICAL AND FINANCIAL INTEGRATION**