Maximizing opportunities for success in the new era of value-based care
Magellan Health: One company, two unique platforms

**Focused on Complex Populations, Delivering Differentiated Services**

State Medicaid programs and integrated management for special populations, including individuals with serious mental illness and those needing long-term services and supports

Behavioral health management and employee assistance programs

Specialty healthcare management, including musculoskeletal, cardiac and advanced imaging

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**MagellanRx**

**Full-Service PBM Focused on High-Growth Specialty Spend**

Full-service Pharmacy Benefit Manager (PBM) that expands beyond traditional core services

Value-driven solutions: targeted clinical and powerful engagement strategies, advanced analytics, leading-edge specialty pharmacy programs

More than 40 years of Medicaid and more than 30 years of self-funded employer experience

Medicare Part D Prescription Drug Program

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**25.3 million**
commercial behavioral lives

**25.1 million**
commercial specialty lives

**5.1 million**
lives in government programs

**Offices in 26 states & D.C.**

**13.3 million**
medical pharmacy lives

**1.9 million**
commercial PBM lives

**26 states & Washington, DC**
in State Medicaid PBA business

**10,000**
Total Employees
Course goals

To recognize critical clinical and organizational competencies that can maximize opportunities for success in the new era of value-based care

Understand how new service delivery and payment models relate to value-based care and system transformation

Identify potential opportunities to identify probability and impact and risk of moving from current process to value-based care using the Project Management Body of Knowledge (PMBOK) models
Learning Objectives

- Identify drivers of value-based care and purchasing
- Identify the components of the healthcare value equation
- Identify key components of value-based collaboration and purchasing
- Explain the role individual providers have in bridging the gap between healthcare cost and quality
- Describe provider expectations to demonstrate value using member-level outcomes tools
- Describe how clinicians can use data to provide value-based care
- Deduce how value-based metrics can identify trends in the populations served by clinicians
- Recognize the direction value-based purchasing is moving in behavioral health, specifically in community-based services
- Recognize system and practice-level changes and competencies that are required to participate in value-based care and purchasing arrangements
What is project management and why do you need it?

• **Think strategically:**
  • Organize right-sized process tools and techniques
  • Environmental factors (EEF’s)

• **Think globally**
  • Beyond enterprise silos
  • Communicating value and purpose for change
    – *Overcoming being change averse*

• **The need to be nimble**
  • Methods and tools have to fit the need
What does project management have to do with value any how?

Value

• Created through the effective management of ongoing operations.

Through effective use of program and project management organizations can:

• Establish processes to meet strategic objectives.
• Obtain greater business value from their project investments.

Not all organizations are business driven

• All organizations conduct business-related activities.

All organizations focus on attaining business value for their activities

• Whether it is a government agency or a nonprofit organization.

The What
“Value” means fair exchange or relative worth...

**Val**-ue

/prəˈvalyoʊ/

1: A fair return or equivalent in goods, services, or money for something exchanged

2: Relative worth, utility, or importance; a good value at the price

[https://www.merriam-webster.com/dictionary/value](https://www.merriam-webster.com/dictionary/value)
...but “value” in healthcare tends to focus more on the payment vs. outcomes and quality

- Health outcomes
- Quality
- Patient experience with care & quality

\[ \text{Divided by cost} = \text{VALUE} \]
Value-Based Purchasing-Payment-Care

What’s the difference?

"The concept of value-based health care purchasing is that buyers should hold providers of healthcare accountable for both cost and quality of care. Value-based purchasing brings together information on the quality of healthcare, including patient outcomes and health status, with data on the dollar outlays going towards health. It focuses on managing the use of the healthcare system to reduce inappropriate care and to identify and reward the best-performing providers. This strategy can be contrasted with more limited efforts to negotiate price discounts, which reduce costs but do little to ensure that quality of care is improved."

Definitions

Value-based purchasing:
• Strategy to improve value (increased quality at lowest cost) of mental health care.
• Realigns incentive structure of healthcare to ensure MCO’s and providers are accountable for delivering high value, good member experience and the most appropriate care (right amount, time and way).

Value-based payment is an example

Value-based payment
• New payment method for healthcare services aimed at rewarding value not volume.

Value-based care:
• The clinical emphasis on outcomes of care versus volume (services, interventions, members).
• Can look different depending on approaches of providers/MCO’s.
The Why
Value-based purchasing yields savings opportunities

Fee-for-service model of healthcare:

2012:
U.S. spent
$2.8 trillion
on healthcare; 17% of GDP

2021:
Estimated U.S.
spend to be
$5 trillion

Spending variation and increases: Not explained by differences or increases in quality in our current models of reimbursement

Why Value-based purchasing (VBP) and reimbursement business case

- FFS penalizes for maintaining health
  less volume less $ versus payment for outcomes

- Value-based reimbursement (VBR) changes rules that control reimbursement
  Income depends not only on service but also quality outcomes, member safety and avoidance of unnecessary variations in care

- VBR two components:
  1. measure value
  2. reform: payment reflects value
Drivers of value-based purchasing

The current landscape

90% of Medicare payments are to be tied to quality metrics by 2018.

Of $500 billion spent in Medicaid, 38 states have contracts and half of those states require providers to be paid through APM’s.

All major commercial payers are investing in VBP with goals of up to 75% of payments tied to value by 2020.

VBP is an economic imperative, not administrative design. This is not going away!

MACRA has 90% bipartisan support

https://www.outcomes.com/2017/01/03/what-does-macra-mean-for-me-and-my-practice/
Behavioral health integration as a VBP focus area is increasing

Increased focus and incentives for networks to support care specifically for behavioral health conditions e.g., Medicare depression screenings, HEDIS mental health and substance abuse measures.

Tracking mechanisms for BH spend being incorporated into TCOC measures for ACOs and ACO-like entities.

RFPs from BH focused entities and ensuing contracts include commitments to VBPs strategies, including numeric targets.
Value-based purchasing is here to stay

- Expansion of VBP models across the continuum of care
- Increasing focus and inclusion of member outcomes into payments
- Expansion of VBP models into non-traditional service areas
- Joint “risk” for member outcomes between providers
- CCBHCs
- BH ACOs
- Bundled rates, episodic rates, case rates
The landscape-Pennsylvania

- HealthChoices Physical Health Managed Care Program moved under a VBR model in 2017.

- A webinar was held on May 25th, 2017 in which VBR was discussed for behavioral health under the HealthChoices Program. Opportunities below were presented:

  - **Opportunities within Behavioral Health**
    - **Pay for Performance (P4P)**
      - Behavioral Health Specific P4P
    - **Care Coordination**
      - Centers of Excellence (COE)
      - Certified Community Behavioral Health Clinics (CCBHC)
      - Physical Health / Behavioral Health Integration
    - **Episode of Care Payment**
      - Assertive Community Treatment (ACT)
      - Inpatient Psychiatric Case Rates
      - First Episode Psychosis (FEP)

The good news is we have already started our journey!!!
Demonstrating the outcomes (value) of BH services is of paramount importance.

**CMS $$$$$$$**

**State Level Funding for HC**

- **County Allocation for BH and D&A**
- **MCO Rates (moving toward VBR %)**
- **Provider Contracted Rates**
- **VBR**

**Rising Healthcare Costs are unsustainable so allocation will be scrutinized**

**Access needs-lower dollars**

- More providers
- or
- Expansion with highest quality providers
Our focused delivery system strategies improve quality, care and outcomes for members, providers and systems

<table>
<thead>
<tr>
<th>MGLN Facility Incentive Program (MFIP)</th>
<th>Assertive Community Treatment (ACT)</th>
<th>Family Based Services (FBS)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Magellan Facility Incentive Program</strong> reduces unwarranted variation in practice patterns to decrease the gap between cost and quality in our facility provider network</td>
<td><strong>Value based program focused on Assertive Community Treatment Providers.</strong></td>
<td><strong>Value based program focused on community based Family Service Providers.</strong></td>
</tr>
<tr>
<td>• 20 facilities in program</td>
<td>• 10 teams across five counties serving approximately 1000 members per quarter</td>
<td>• 20 teams serving approximately 1000 families per quarter</td>
</tr>
<tr>
<td>• Account for over 90% of IP volume and spend across five counties</td>
<td>• Overall community tenure rate exceeds 90%.</td>
<td>• Reimburses based upon community tenure, transitions in care and functional outcomes</td>
</tr>
<tr>
<td>• Overall outcomes of program show more facilities moving toward expected outcomes benchmarks</td>
<td>• Reimburses based upon community tenure and fidelity to established practice standards</td>
<td></td>
</tr>
</tbody>
</table>

To impact the gap between quality and cost Magellan has designed value-based models specifically focused on high volume high cost levels of care/services and all providers within the level of care/service across all counties

26% of Magellan of PA total care dollars are under value based reimbursement models
VBP facilitates quality care for providers, cost efficiency for payers and value for consumers

<table>
<thead>
<tr>
<th>Providers</th>
<th>Payers</th>
<th>Consumers</th>
</tr>
</thead>
</table>
| ✓ Additional TA  
✓ Consistency  
✓ Learning collaborative  
✓ Data – system level  
✓ Comparative outcomes  
✓ Reduced UM  
✓ Published preferred provider status  
✓ Reimbursement – aligned with performance | ✓ Data-based decision-making for reimbursement and incentives  
✓ Quality of programs  
✓ Best-performing providers  
✓ Improved provider engagement tools | ✓ Enough information to choose the best provider for their needs  
✓ Increased satisfaction  
✓ Improved outcomes |

Quality + Cost = Value
At the end of the day...

We are all consumers of healthcare
The How
With VBP, systems mature as they transform from fragmented to collaborative

**Fragmentation**
- Narrow focus
- Grant funding
- Scattered data collection
- Outcomes are not collected or data is not leveraged

**Independence**
- FFS
- Interdisciplinary team focus
- Data is not used to drive decisions; it is only financial OR clinically focused; OR it is not shared across the organization
- Rating scales may be used, some outcomes measures

**Collaboration**
- Value-based care
- Whole-person approach
- Alternate payment arrangements
- Data drives decisions
- Data is driven down through organization

**Transformation**
It takes time for clinicians to adapt from independent thinking to system collaboration

Metrics and incentive payment shift in progression; over time, clinical practice will need to change

**Learning the behavior and expectations**
- Pay for participation
- One-time payments
- Temporary rate increases

**Modifying behavior to fit expectations**
- Scorecards that include quality and efficiency
- Financial and non-financial incentives

**Changing care delivery**
- Outcomes-based incentives
- Value definitions
- Overall payment is tied to performance
- Risk for member outcomes is increasing
- Collaboration with other levels of care within the episode of care

**System transformation care delivery**
- Joint metrics across levels of care/shared incentive
- Rates or payment arrangements are aligned with member/system outcomes

Adapted from The Physician Alignment Initiative
Ways payment can drive system transformation

**Current payment system**
- Fragmented delivery system (clinical and financial)
- Gaps in care and uncoordinated care transitions
- Unengaged members with lack of information or support to make healthcare decisions
- Gaps in cost and quality leading to variation in delivery system performance.
- Lack of accountability and transparency

**Transformed system**
- Integrated systems & care models (CCBHC’s)
- Coordinated care and transitions in care
- Empowered members who take a greater role in the care they chose to receive
- Standardized performance measurement and transparency for improved health outcomes
Clinicians adopt, disseminate population health strategies, then use data to drive practice interventions – such as value-based care

- **Defined value**: The use of data, algorithms, standardized equitable measures and actionable information to identify and define provider value.
- **Provider engagement**: Early and ongoing engagement through data and an understanding of what is being measured, why and how it’s being measured.
- **Transparency**: Public reporting to drive performance improvement. Consumer transparency for selection of highest-quality providers.
- **Payment alignment**: Reimbursement is based upon performance incentives are aligned with definition of value.
- **Informed choice**: Consumers, customers and payers have the right information to make informed decisions about choice of care, network and contracting.

UM to care coordination >> Member-facing provider profiles >> Member outcomes data
VBP roadmap: Shared outcomes will yield increased system collaboration into 2018

2017: Focus will be on opportunities for collaboration between levels of care (IP and community-based)

2017-2018 Joint metrics used as part of incentive payment

2018 Functional outcomes as part of scorecard

Defined value Provider engagement Transparency Payment alignment Informed choice Delivery system collaboration
Self Assessment Time
Organizational & Provider Competencies
Organizational competencies

STRONG LEADERSHIP

WORKFORCE ADEQUACY

CULTURE OF READINESS & INNOVATION

STRATEGIC ALIGNMENT AROUND POPULATION HEALTH & NEW CARE DELIVERY MODELS

FINANCIAL PERFORMANCE & ANALYTIC CAPABILITIES

HIGH FUNCTIONING COMPLIANCE AND QI PROGRAMS
Clinicians play an integral role in providing insight for and oversight of VBP and VBC initiatives.
Population health management

• A set of interventions designed to maintain and improve a patient’s health across the full continuum of care—from low-risk, healthy individuals to high-risk individuals with one or more chronic condition. (Felt-Lisk & Higgins, 2011)

• Population management requires providers to develop the capacity to utilize data to risk stratify patients into groups and then respond to the needs efficiently and effectively
Clinicians need the right skills, knowledge and abilities to participate in VBP and VBC initiatives

Best practices/EBPs

**Whole-person treatment approach**
- Social determinants of health
- Social service connections
- Care coordination abilities

**Ability to work in new models of care**
- Inter-professional treatment teams

**Use of assessment and outcomes tools**

**Understand how services are reimbursed**

**Basic CQI**
VBP and population health:
Understanding performance at all levels is everyone’s responsibility

Efficient healthcare:
• Clinical and administrative work flow processes that operate within optimal time and cost specifications.

Organization:  Outcomes at population served level

Individual clinician: Individual member: Measurement based care
• Right patient need(s) identified
• Right treatment(s) provided
• By the right professional(s)
• At the right time(s)
• Producing the right health and satisfaction outcome
The paradigm is shifting from rewarding fee-for-service to rewarding cost/quality and outcomes

**Current achievement**
- High volume (services/members)
- High Independence
- Tradition utilization management
- Compliance with documentation requirements

**New accomplishments**
- Demonstrated outcomes
- Improved compensation based upon outcomes
- Data driven/culture of innovation
- Partnerships with payers, providers, social services
  - Gaps in care
  - Care management

Rewarding fee-for-service  >>  Rewarding cost/quality and outcomes
The paradigm has shifted from rewarding fee-for-service to rewarding cost/quality and outcomes

Current thinking
• It is hard to measure behavioral health outcomes
• We have stories of our member outcomes
• We don’t have enough volume of membership to make an impact on the healthcare system

Paradigm shift
• We need to collaborate with the rest of the system to serve our members
• We have data to show the value we create in our members’ lives and within the healthcare system
• Behavioral health providers are an important part of the healthcare system
• We need to leverage measurement-based outcomes to drive our clinical interventions
Getting From Here to There
**VBP: stages of system transformation**

*Making readiness concrete*

<table>
<thead>
<tr>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
<th>Stage 4</th>
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<tbody>
<tr>
<td>We use EDI/EFT and know our %. We know our claims denial % and reasons.</td>
<td>Cases are assignment by acuity. Some clinical pathways are used for treatment. My organization uses screening tools &amp; EBP’s</td>
<td>Our organization uses screening and outcomes tools data and shares the data with our staff</td>
<td>Demonstrated outcomes (population level)</td>
</tr>
<tr>
<td>Our/my licensure is active-no compliance issues within the last year.</td>
<td>My organization/I know Readmission rates-7 day FUH-ALOS-ANOS</td>
<td>Population Health Mgmt. Strategies are known &amp; employed We know our highest cost members.</td>
<td>We employ population health mgmt. strategies for our high need/cost members</td>
</tr>
<tr>
<td>MCO’s would agree that my organization meets understands MNC-case conceptualization</td>
<td>My organization/I have Key Performance Indicators and they are monitored.</td>
<td>Clinicians evaluate their sessions. We use measurement based care theories/tools</td>
<td>My organization/I have demonstrated outcomes as a result of our CQI strategy &amp; plan</td>
</tr>
<tr>
<td>My organization/I use MCO administrative tools. My provider data is up to date.</td>
<td>My organization/I know information about the costs of services. Information from finance</td>
<td>Data Driven-Financial &amp; Clinical data is used to drive decisions and is shared. Root cause analysis is used</td>
<td>My organization/I have relationships/partnerships with other providers</td>
</tr>
<tr>
<td>My organization captures encounters and can report on encounters.</td>
<td>My organization has an EMR or automated clinical and data tools.</td>
<td>My organization uses an EMR to extract data and data is actionable.</td>
<td>My organization/I have clear processes &amp; practices to manage transitions/gaps in care</td>
</tr>
</tbody>
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**System Fragmentation**

- STRONG LEADERSHIP
- WORKFORCE ADEQUACY
- CULTURAL READINESS & INNOVATION
- STRATEGIC ALIGNMENT
- POP. HEALTH AND NEW CARE DELIVERY MODELS
- FINANCIAL PERFORMANCE
- HIGH FUNCTIONING QI & COMPLIANCE

**System Transformation**

P4Participation - One time payment - Scorecards tied to financial incentives (quality/cost) - Rates aligned with member outcomes
Learning objectives recapped

- Identify drivers of value-based care
- Identify the components of the healthcare value equation
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- Explain the role individual providers have in bridging the gap between healthcare cost and quality
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Key take-aways

- Barriers are surmountable
- Joint efforts across QI/clinical/network/finance
- Count the “small” stuff
- Great is the enemy of good – but improvements can be made
- Collect outcomes
- Use data to drive outcomes
- Never assume everyone is on the same page (rinse, lather, repeat)
- Value-based purchasing and care is not a destination
- Project management practices and principles play a key role in success in VBP models
- One size DOES NOT fit all!