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Navigating Value-Based Payment Approaches

September 2021

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Questions for Today!

1. Why the focus on Value-Based/Alternative Payment Models?
2. What is a Value-based/Alternative Payment Model?
3. What are the national trends in the use of these models in carve-in vs. carve-out markets?
4. What is the impact of COVID-19/telehealth on these models?
5. How can providers succeed in this environment?
6. What are your thoughts, questions, and lessons learned?

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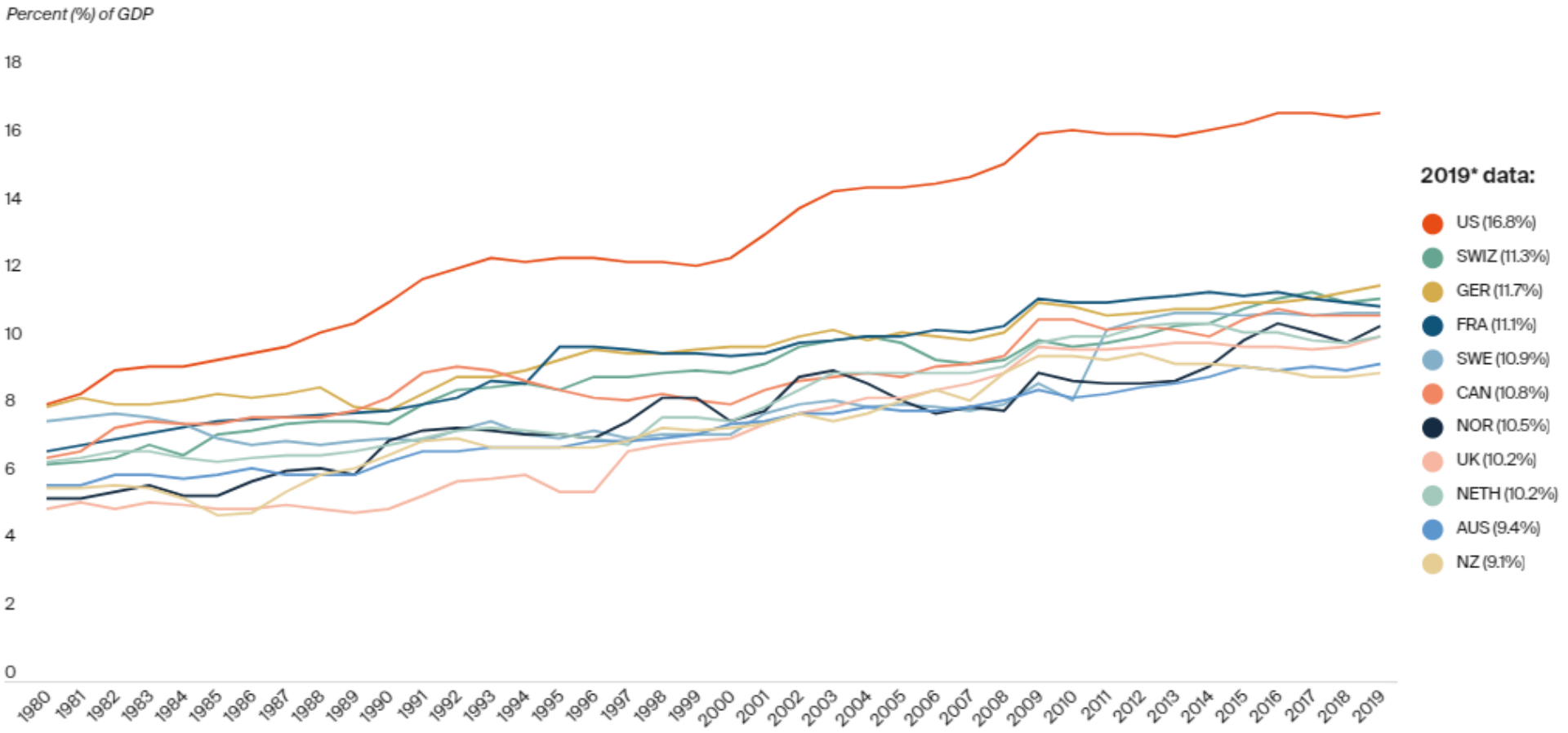
"Incredible, but is it billable?"

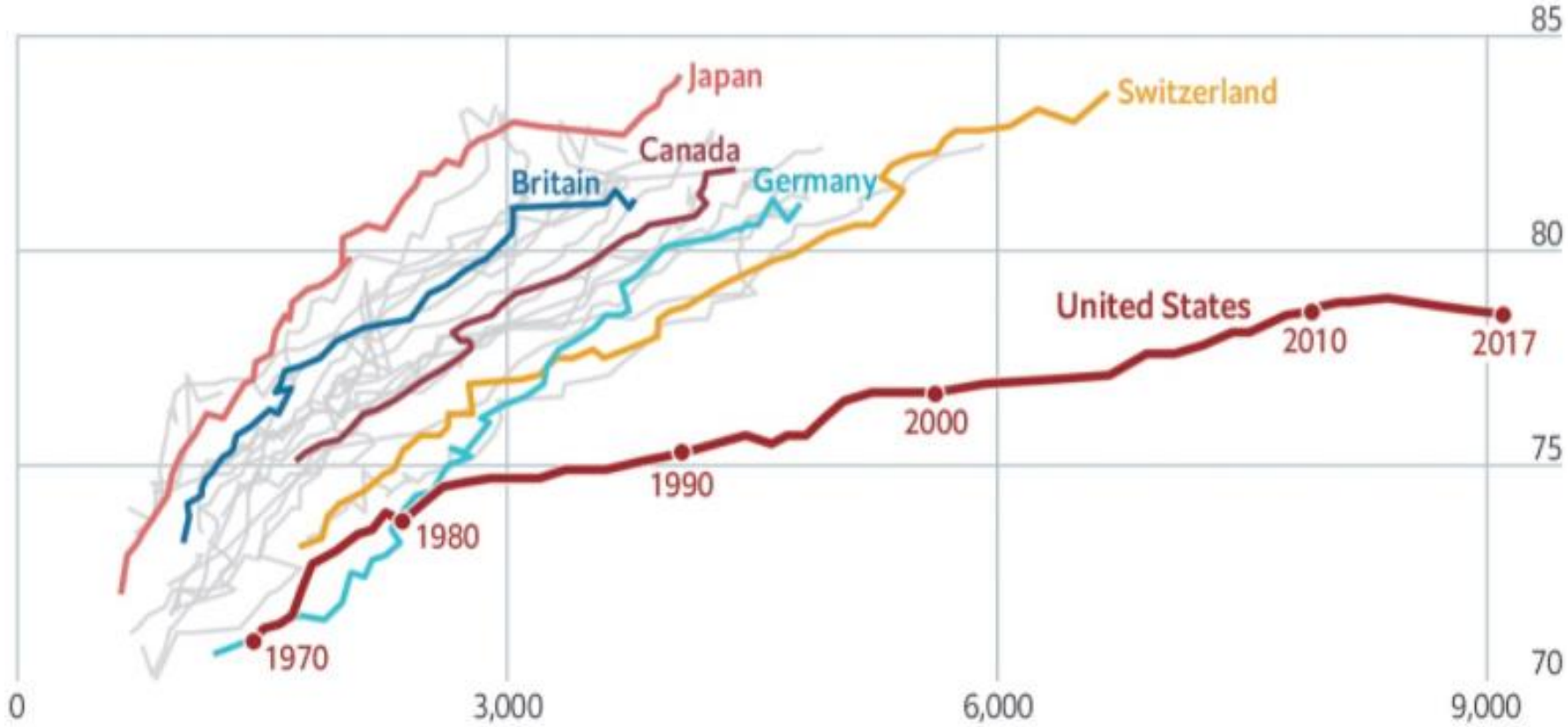
Health Care Spending as a Percentage of GDP, 1980–2019



Notes: Current expenditures on health. Based on System of Health Accounts methodology, with some differences between country methodologies. GDP refers to gross domestic product.
* 2019 data are provisional or estimated for Australia, Canada, and New Zealand.

Odd man out

Health spending and life expectancy, 1970-2017*, selected OECD countries



Source: OECD

*Or latest available

The Economist

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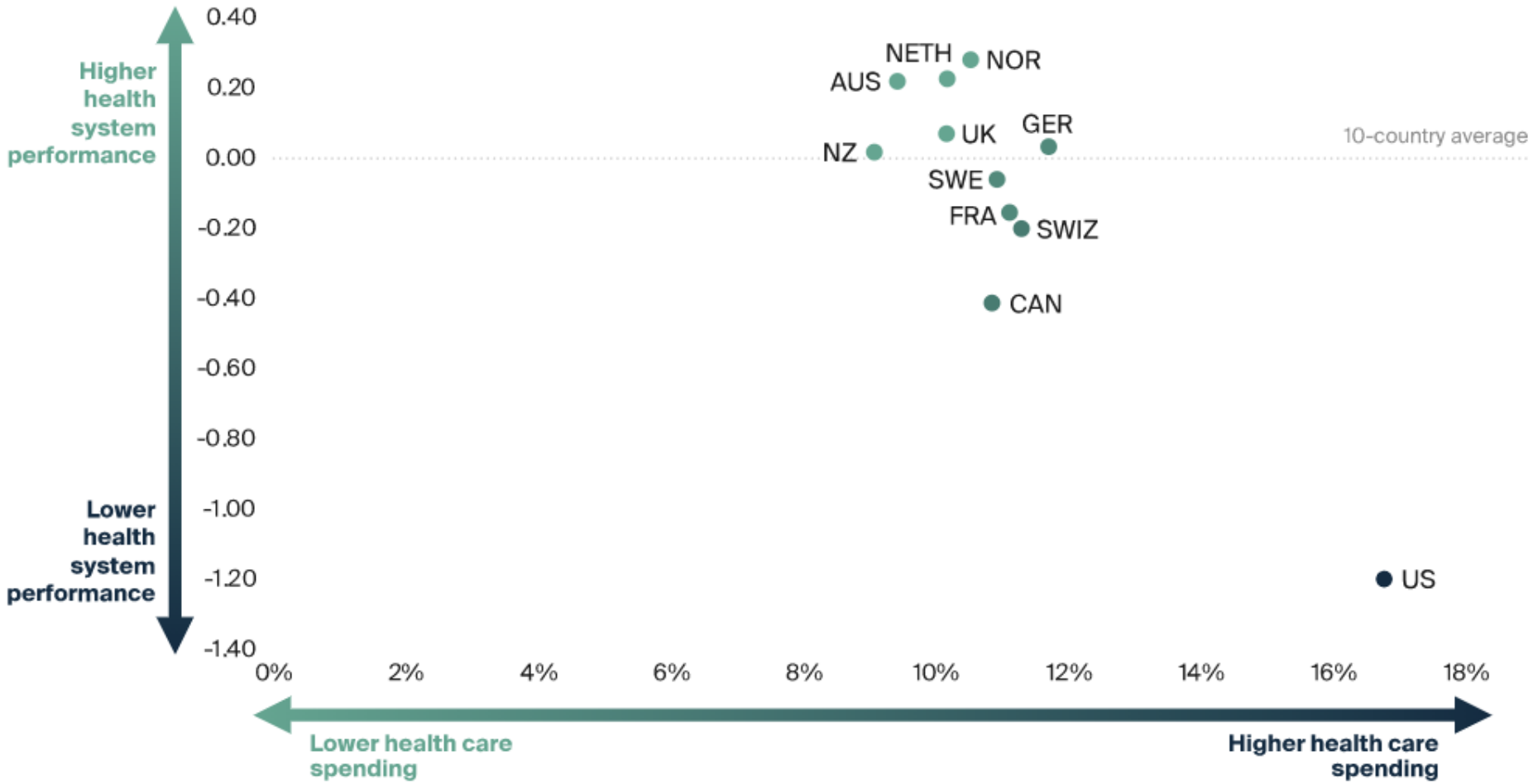
Health Care System Performance Compared to Spending



Note: Health care spending as a percent of GDP. Performance scores are based on standard deviation calculated from the 10-country average that excludes the US. See How We Conducted This Study for more detail.

Data: Spending data are from OECD for the year 2019 (updated in July 2021).

Source: Eric C. Schneider et al., *Mirror, Mirror 2021 — Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries* (Commonwealth Fund, Aug. 2021). https://doi.org/10.26099/01DV-H208

Health Care System Performance Rankings

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING	**3**	**10**	**8**	**5**	**2**	**6**	**1**	**7**	**9**	**4**	**11**
Access to Care	8	9	7	3	1	5	2	6	10	4	11
Care Process	6	4	10	9	3	1	8	11	7	5	2
Administrative Efficiency	2	7	6	9	8	3	1	5	10	4	11
Equity	1	10	7	2	5	9	8	6	3	4	11
Health Care Outcomes	1	10	6	7	4	8	2	5	3	9	11

Data: Commonwealth Fund analysis.

Source: Eric C. Schneider et al., *Mirror, Mirror 2021 – Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries* (Commonwealth Fund, Aug. 2021).
https://doi.org/10.26099/01DV-H208

Commonwealth Fund 2021 Mirror Mirror Report

Value-based Purchasing
An Old Term Getting New Life

"The concept of value-based health care purchasing is that buyers should hold providers of health care accountable for both cost and quality of care. Value-based purchasing brings together information on the quality of health care, including patient outcomes and health status, with data on the dollar outlays going towards health. It focuses on managing the use of the health care 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."

Source: Theory & Reality of Value-Based Purchasing: Lessons from the Pioneer. November 1997. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/meyer/index.html

Effective & Efficient Healthcare

Effective Healthcare:

- Producing quality outcomes, health literacy & excellent customer experience of care & satisfaction

Efficient Healthcare:

- Clinical & administrative processes that operate within optimal time & cost specifications

Fee-for-Service/Volume Based Care =>

Focus is on Efficiency

Value Based Purchasing =>

Focuses on Both Efficiency & Effectiveness

Fee-for-Service Calculations

Total Cost for Service Delivery

- Direct Service Staff Salary
- Direct Service Staff Fringe Benefits
- Non-Direct Costs (All other costs)

Total Revenue for Service Delivery

- Net Reimbursement actually Attained/ Deposited. *(This takes into account Denial Rate, Self Pay, Sliding Fee Scale, etc.)*

- Divided By -

Total Billable Direct Service Hours Delivered **

- All Direct Service Hours Delivered by Direct Service Staff that are eligible to be billed via a CPT Code or against a Grant.

** Utilizing the common denominator of total Billable Direct Service Hours instead of total hours worked per year assures an apples to apples comparison of an organization's true cost versus revenue per direct service hour.

MTM SERVICES
www.mtmservices.org

How Health Care Providers Get Paid

- **Payer**
  - Medicaid / Medicare
  - Commercial Insurance
  - Grant / Foundation
- **Credentialed Organization**
  - Licensure / certification
  - Liability coverage
  - Contract with payer
- **Credentialed Staff**
  - Licensure
  - Liability coverage
- **Professional Need Assessment**
  - Diagnosis
  - Level of care
  - Documentation of Service
- **Coding for Services Provided**
  - HCPCS / CPT Codes

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The Value Equation Integrates Quality Data with Dollars

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Defining Our Terms…ya right!

Bundled payment, also known as **episode-based payment**, **episode payment**, **episode-of-care payment**, **case rate**, **evidence-based case rate**, **global bundled payment**, **global payment**, **package pricing**, or **packaged pricing**, is defined as the reimbursement of health care providers "on the basis of expected costs for clinically-defined episodes of care." [1][2][3][4][5]

Bundled payment has been described as "a middle ground" between **fee-for-service reimbursement** (in which providers are paid for each service rendered to a patient) and **capitation** (in which providers are paid a "lump sum" per patient regardless of how many services the patient receives), given that risk is shared between payer and provider.[6]

1. Cromwell J, Dayhoff DA, Thoumaian AH (1997). "Cost savings and physician responses to global bundled payments for Medicare heart bypass surgery". Health Care Financ Rev. **19** (1): 41–57. PMID 10180001.
2. Miller J (1 June 2008). "Package pricing: Geisinger's new model holds the promise of aligning payment with optimal care". Managed Healthcare Executive. Retrieved 2010-03-11.
3. Commonwealth of Massachusetts, Special Commission on the Health Care Payment System (16 July 2009). "Recommendations of the Special Commission on the Health Care Payment System. Appendix C: memos on basic payment models and complementary payment-related strategies" (PDF). Retrieved 2010-03-11.
4. Satin DJ, Miles J (2009). "Performance-based bundled payments: potential benefits and burdens" (PDF). Minn Med. **92** (10): 33–5. PMID 19916270.
5. Miller HD (2009). "From volume to value: better ways to pay for health care". Health Aff (Millwood). **28** (5): 1418–28. doi:10.1377/hlthaff.28.5.1418. PMID 19738259. Archived from the original on 2013-04-15.
6. RAND Corporation. "Overview of bundled payment".

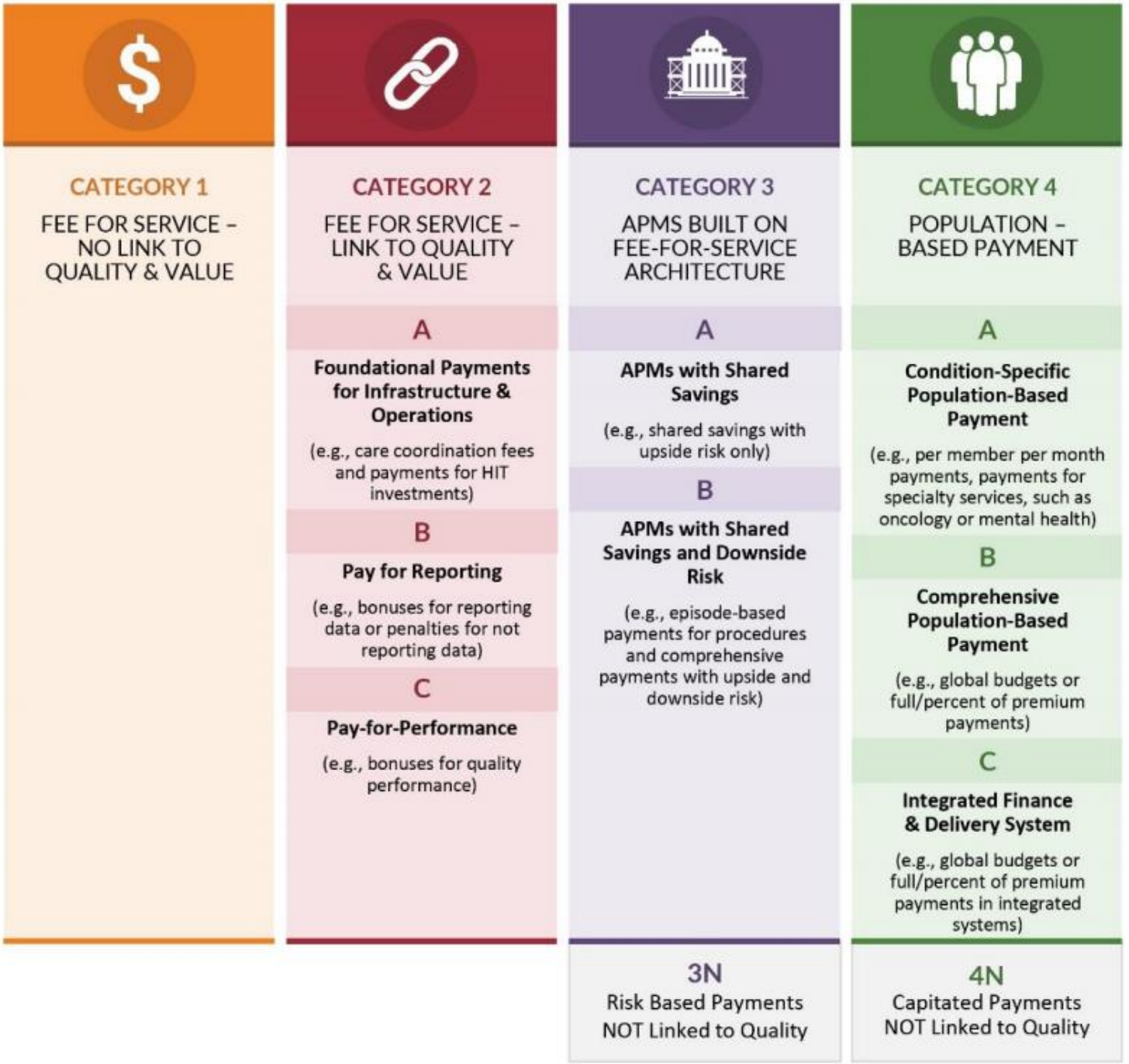
Defining Our Terms…little better!

- **Fee-for-Service:** Provide a service receive a payment fee. Often called procedural or volume-based medicine approach.

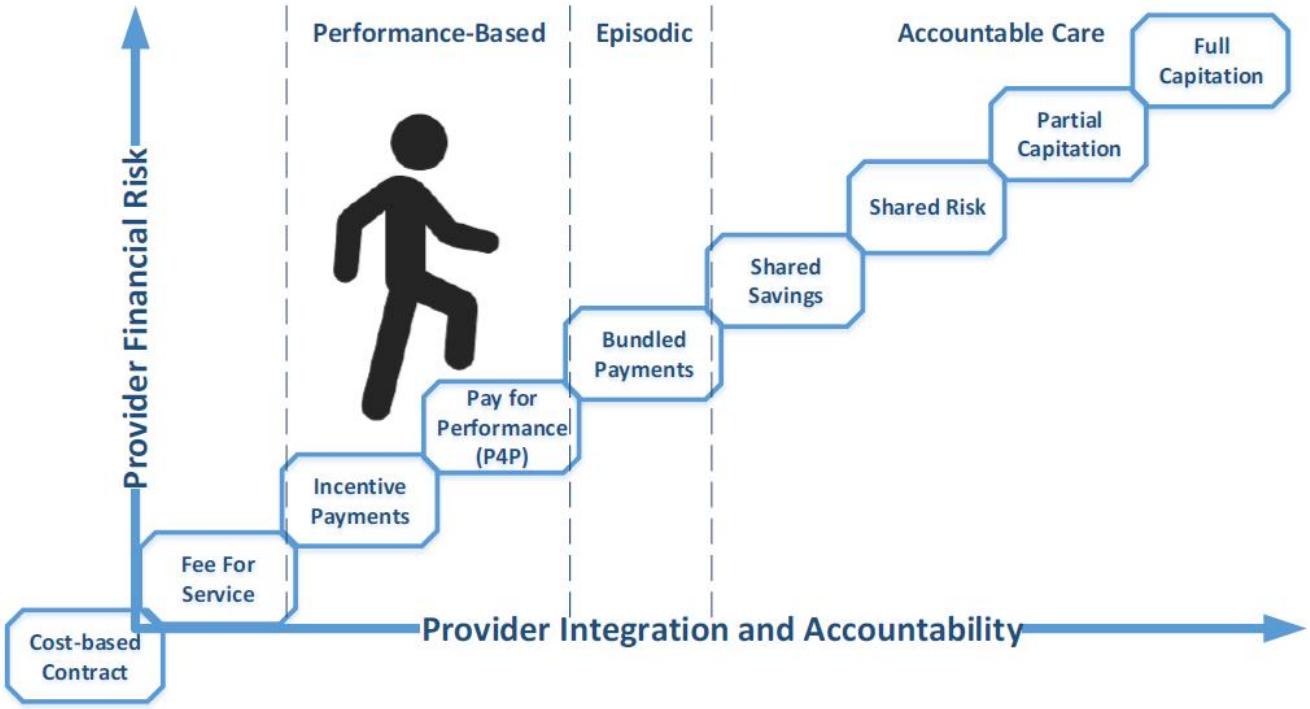
- **Bundled Rate/Payment:** General term to describe a variety of payment methods where fees are combined (e.g., capitation, case rate, prospective payment rate, episode of care, etc.).

Health Care Payment Learning & Action Network (HCP-LAN)

Alternative Payment Model (APM) Framework



Value-based Payment



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HCP-LAN & Centers for Medicaid/Medicare (CMS) Targets

	Medicaid	Commercial	Medicare Advantage	Traditional Medicare
2020	15%	15%	30%	30%
2022	25%	25%	50%	50%
2025	50%	50%	100%	100%

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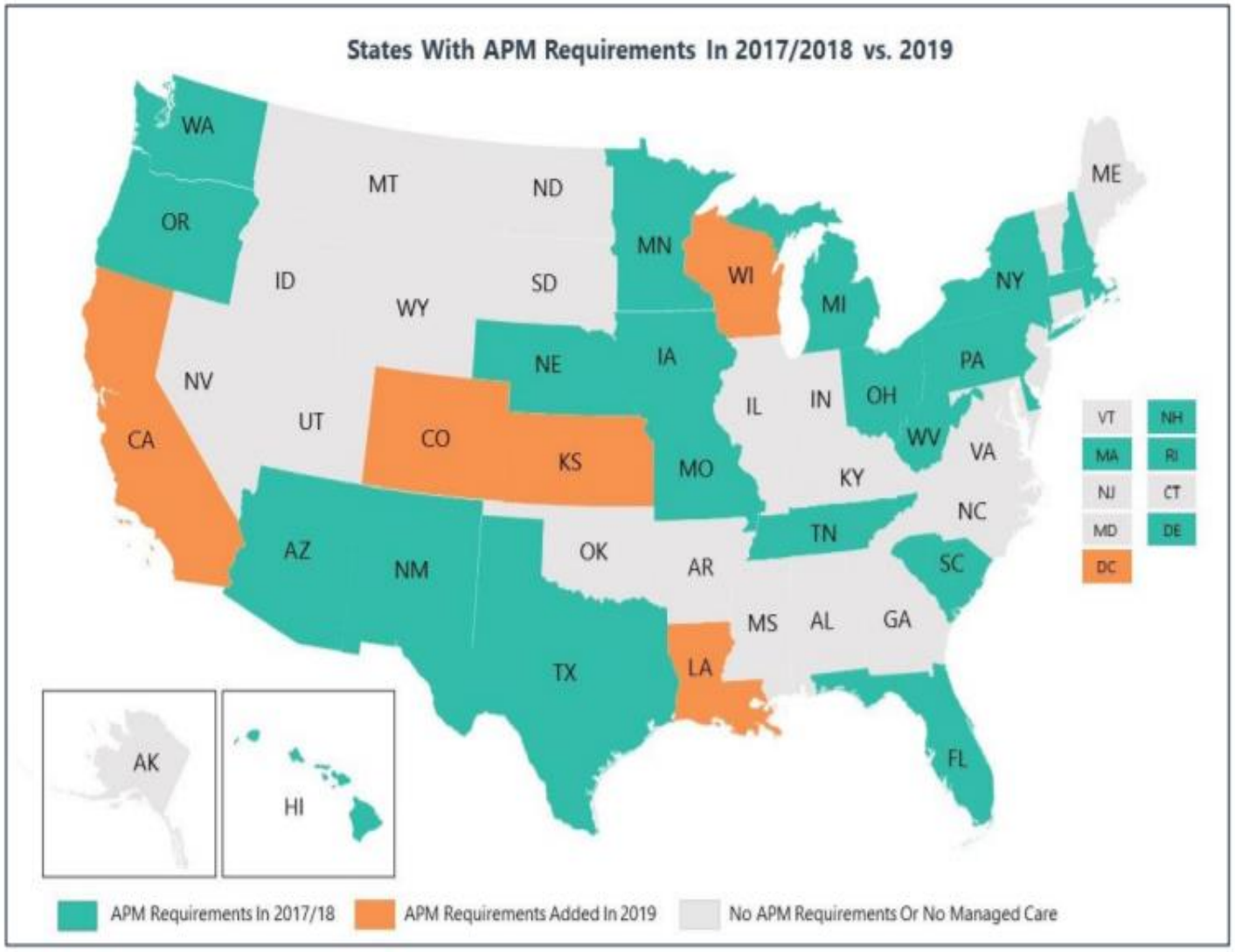

22 state Medicaid plans require their health plans to implement value-based provider reimbursement

- At least 11 states have Medicaid ACOs
- 81% of Medicaid health plans have P4P FFS payments for behavioral health organizations
- 47% of Medicaid health plans have bundled payments for specific acute episodes

Source: OPEN MINDS.com

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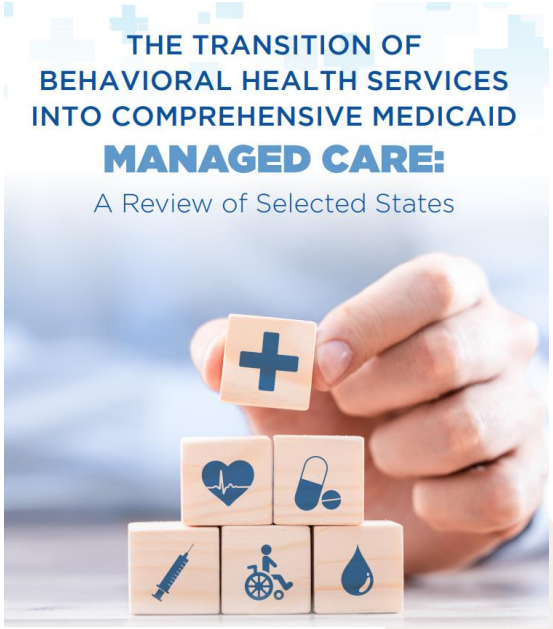
Carve-in/Carve-out Managed Care

23 states have carve-in behavioral health services

Actual execution of behavioral health carve-in models by MCOs in commercial coverage has not proven to be consistent with the community standard of care and have been more restrictive than the standard of care.
(see: https://www.thenationalcouncil.org/standards-of-care/)

It is true that carving the behavioral health benefit into managed care increases administrative costs for both Medicaid and for providers. Administrative costs to Medicaid, Medicaid fee-for-service (FFS) average between 4% and 6% while Medicaid managed care plans administrative costs average 14% due to larger staff that is are paid higher salaries compared to state employees managing FFS Medicaid programs.



Source See: https://www.thenationalcouncil.org/commentary-by-dr-joseph-parks-on-findings-from-the-transition-of-behavioral-health-services-into-comprehensive-medicaid-managed-care-a-review-of-selected-states/

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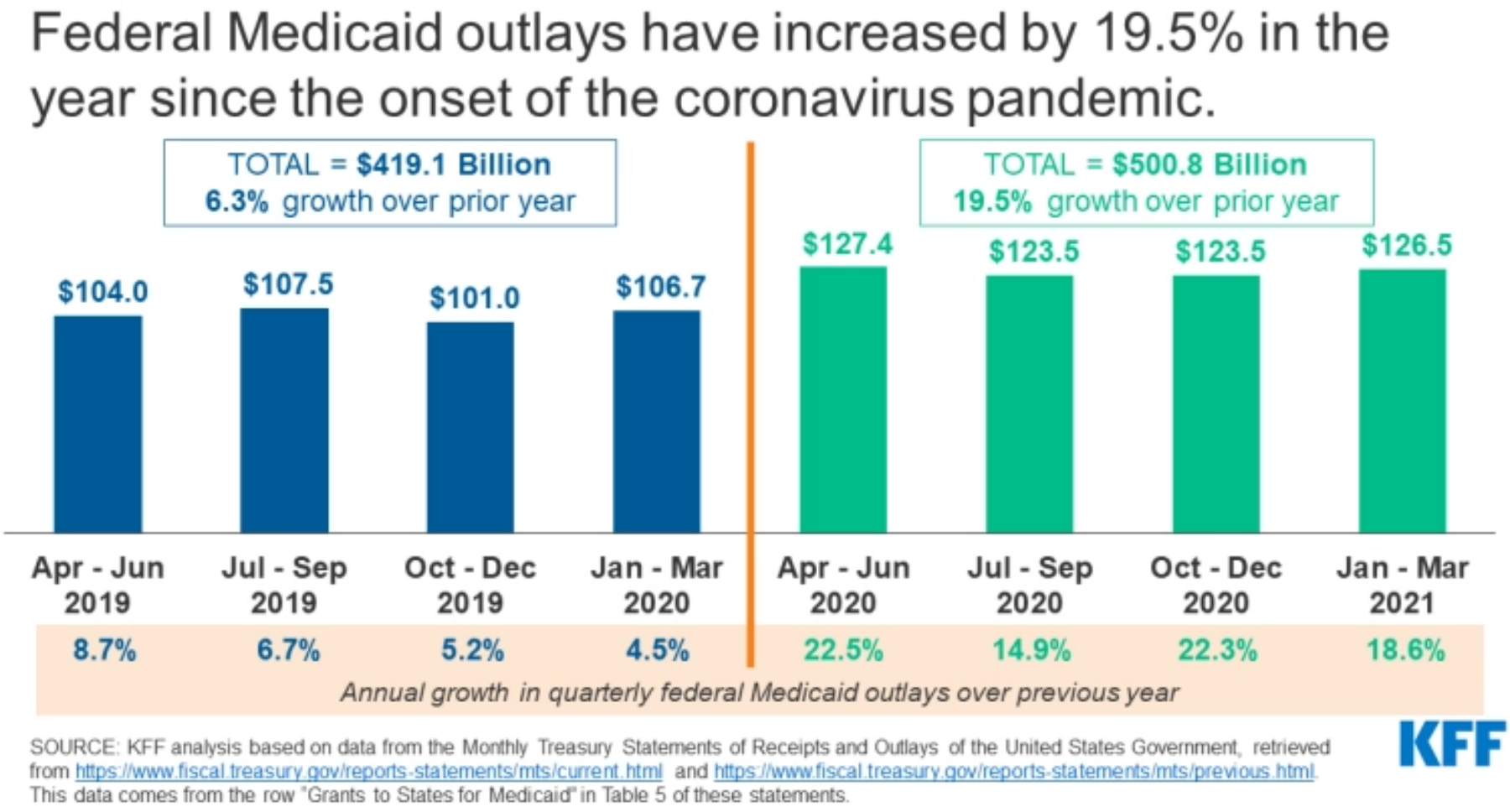
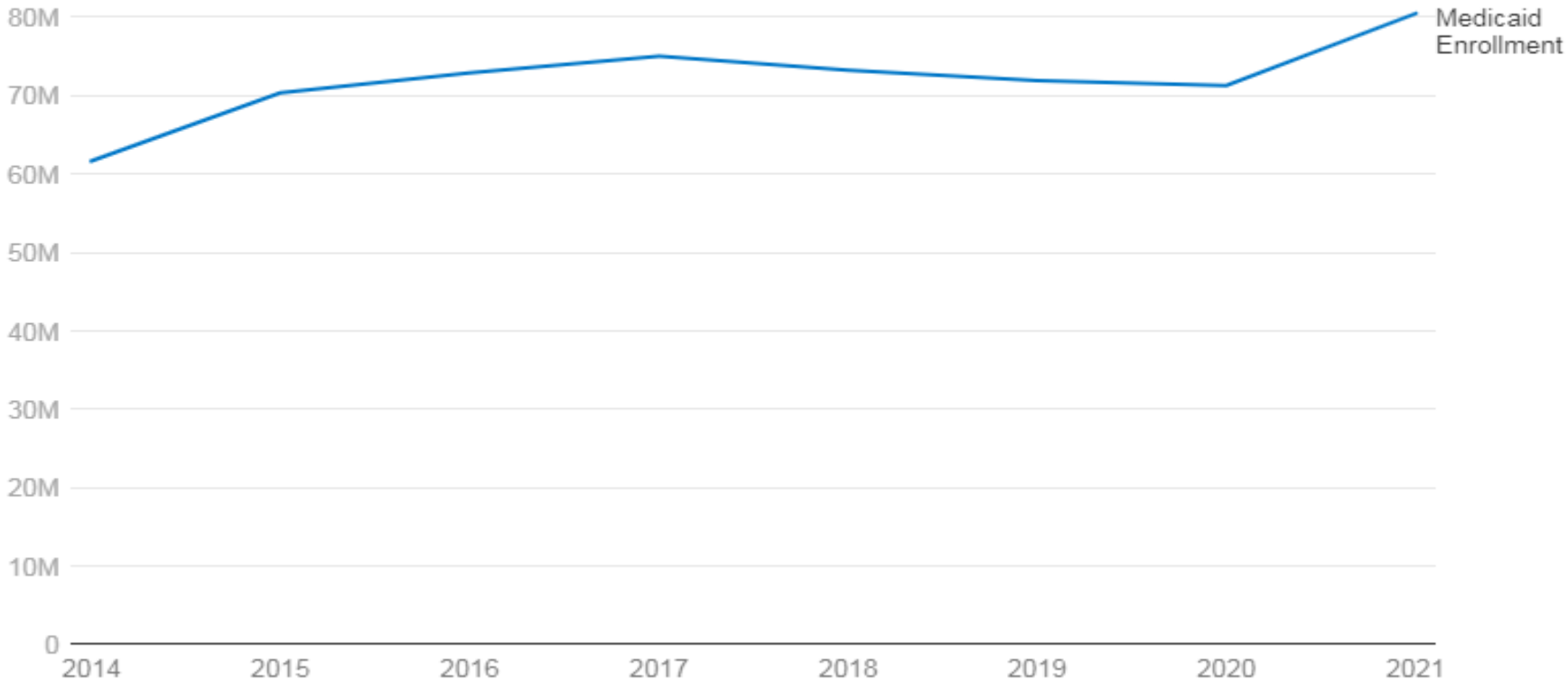


Figure 1: Federal Medicaid outlays have increased by 19.5% in the year since the onset of the coronavirus pandemic.

ACA and Covid Boost Medicaid Enrollment

Medicaid enrollment surpassed 80 million people for the first time in January 2021. That's up from about 56 million in 2013, just before many states expanded Medicaid under the Affordable Care Act.



NOTE: Data includes the Children's Health Insurance Program
SOURCE: KFF • Embed

KHN

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COVID-19
Telehealth Impact on VBP

- Must address payment parity, deign (i.e., fee-for-service or Value-based), workforce challenges (e.g., cross state licensure) beyond the public health emergency
- Need to address geographic and originating site restrictions on the use of telehealth (e.g., establish the patient's home as an eligible distant site)
- Need to continue to study the use of telehealth during COVID, including its costs, uptake rates, measurable health outcomes, and racial and geographic disparities…studies are showing telehealth is it is not cheaper for providers.
- Telehealth fee-for-service models are harder to evaluate from the standpoint of quality, providers must take into consideration/track what it takes to do telehealth including modality (audio-only versus audio/video), timing (real time versus asynchronous), location (office, home, partner agency), and clinical condition of those served including complexity.

Sources: Harmony Solutions Advancing VBC through Telehealth (https://harmony.soluteons/advancing-value-based-care-through-telehealth/)
Health Affairs (2021) Use Value-Based Payment To Resolve The Debate About Telehealth Payment Parity https://www.healthaffairs.org/do/10.1377/hblog20210726.882779/full/

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Value-Based Reimbursement Competency

Source: OPEN MINDS.com

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"Risk comes from not knowing what you are doing…"

--Warren Buffett

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Financial Risk

Utilization Risk –

- The estimate of the amount of service that the covered population will use/require (e.g., average lengths of stay, average visits per case, & accurate assignment to a level of care) is wrong.
- Staff providing too much or too little service to a client (i.e., misalignment of services with the clients needs).

Right Client, Right Service, Right Time

What can you do?

1. Leverage what you already do to show your value and better measure care provision through Team-based Care Pathway Analysis

2. Use/Adopt **Change Management Technology**

3. Develop and aggressively use your **Value Proposition** to negotiate contracts

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Team-based Care Pathway Approach

Team Based Care See: https://www.thenationalcouncil.org/about/national-council/medical-director-institute/
Care Pathways See: https://www.thenationalcouncil.org/wp-content/uploads/2020/03/Toolkit-for-Designing-and-Implementing-Care-Pathways.pdf?daf=375ateTbd56

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Five Components of Effective Interdisciplinary Teams:

1.The establishment of safe environment.

2. Defining shared team goals.

3. Clear role expectations for team members.

4. A flexible decision-making process.

5. The ability of the team to “treat” itself.

Source: Leipzig, Hyer et al. (2002). Attitudes Toward Working on Interdisciplinary Healthcare Teams:

A Comparison by Discipline J Am Geriatr Soc 50:1141–1148.

Team-base Care Pathways

Standardized set of protocols describing processes or care management guidelines developed by a clinic team to screen, assess, treat, and monitor clients with a specific health condition or social determinant need.

Care pathways include both clinical (e.g., prescribing, therapy, etc.) and administrative (e.g., reviewing data, team meetings, billing, etc.) workflow behaviors which staff engage in when delivering care.

Steps for Designing and Implementing a Care Pathway

1. **IDENTIFY** a client population.

2. **ASSIGN** an interdisciplinary quality improvement team.

3. **RESEARCH** the evidence-based or best practice guidelines associated with identified need(s) of the population.

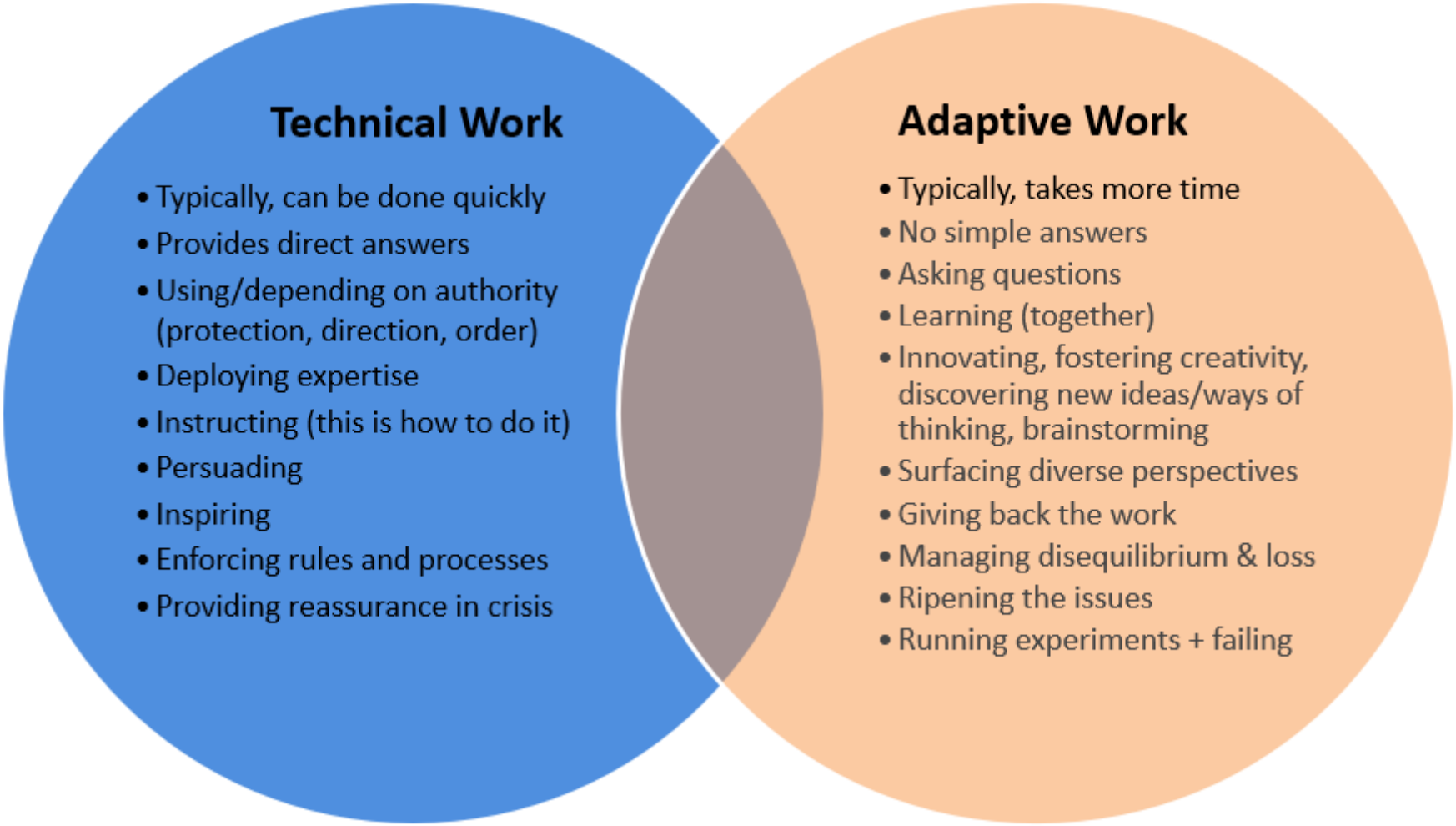
4. **MAP** the current state of services provision and identify areas for improvement.

5. **DEVELOP** the revised care pathway protocol(s).

6. **TEST** the new protocol(s) using Plan-Do-Study-Act.

7. **IMPLEMENT** the new care pathway and monitor using continuous quality improvement.

Change Management



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Developing Your Value Proposition

- ✓ Documenting what benefit your organization provides, for whom, and how you do it uniquely well (i.e., efficiently and effectively).
- ✓ Builds the case that you are better positioned to meet the community's need than your competitors.
- ✓ A living document that can be updated as needed and is tailored to different audiences.

DEVELOPING YOUR VALUE PROPOSITION:
A STEP-BY-STEP GUIDE FOR BEHAVIORAL HEALTH PROVIDERS

See: https://www.thenationalcouncil.org/wp-content/uploads/2020/03/developing-your-value-proposition-a-step-by-step-guide-for-behavioral-health-providers_final.pdf?daf=375ateTbd56

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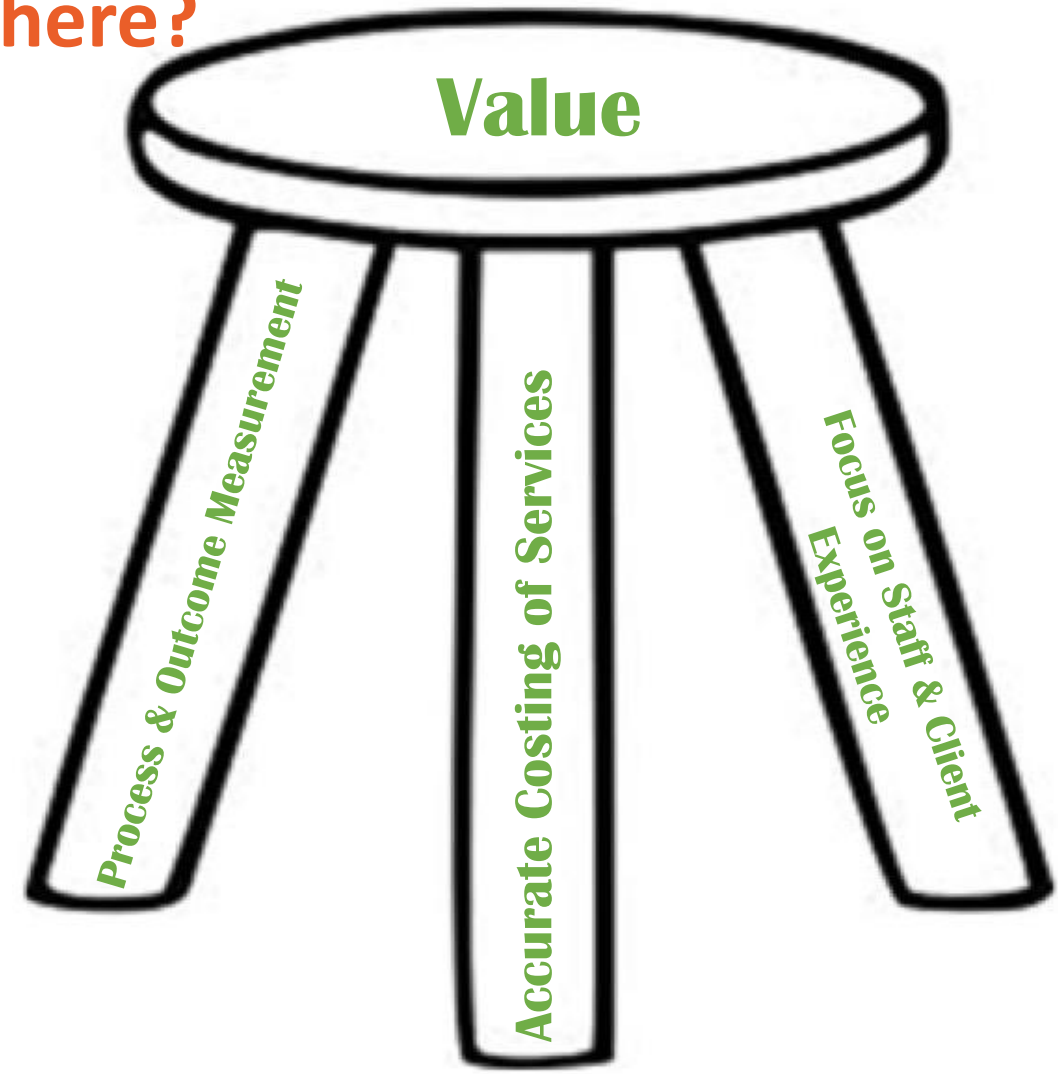
Where do we go from here?

- Executive/Middle Management must adopt and follow a change management approach/technology
- Continue to aggressively negotiate value-based contracts w/ County/Medicaid/MCO's
- Adopt/Buildout Certified Community Behavior Health Clinic (CCBHC)
- Increase focus on your value proposition to the clients, your staff and the funders
- Remember you are creating value/doing the needed work…it is a matter of refining/polishing and being bold enough to get credit for what you do!



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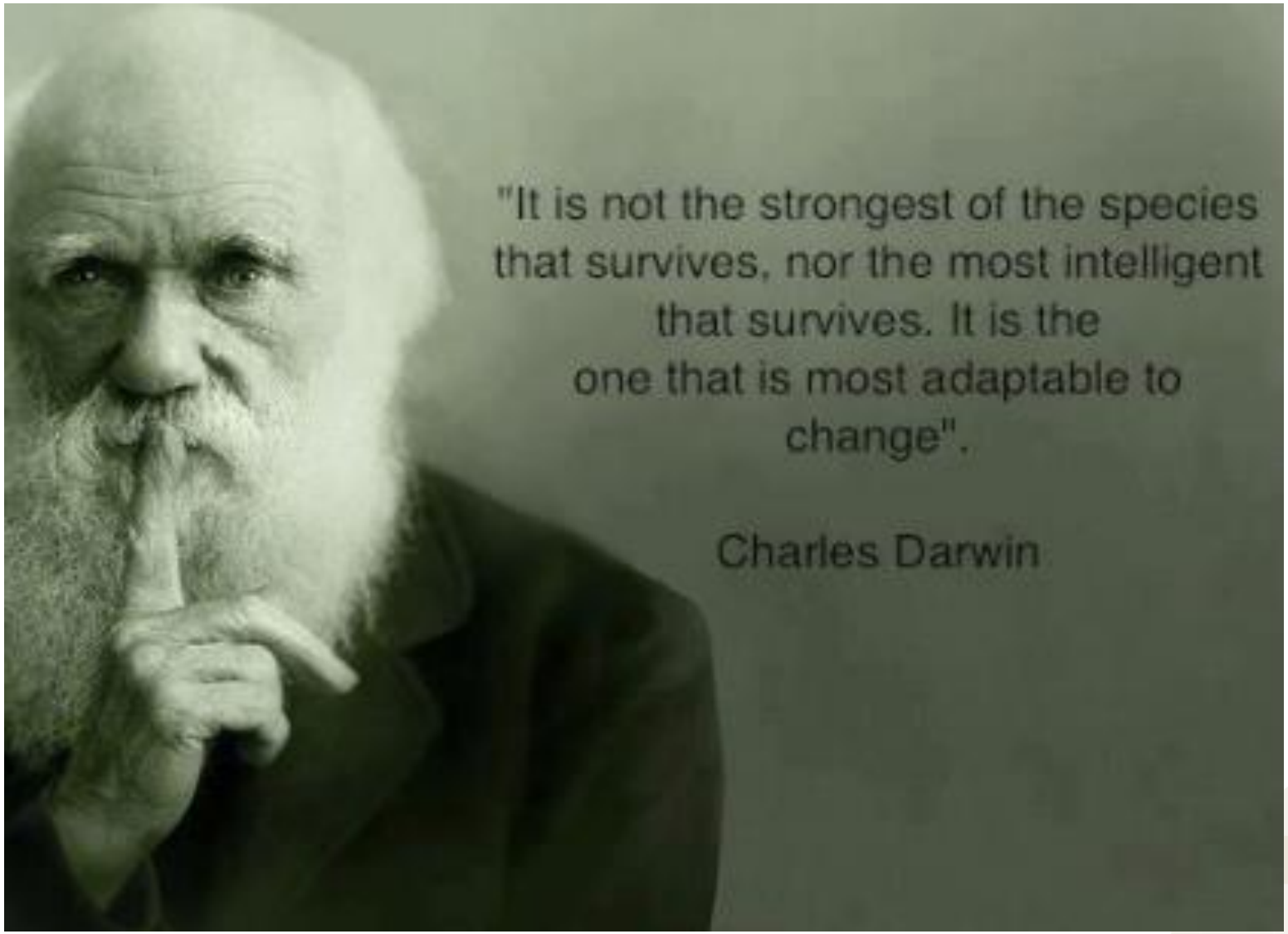

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Thank you!

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