Value-Based Payments and Community Behavioral Health

Part 2: Infrastructure Needed for payment and practice transformation

New York State Council for Community Behavioral Healthcare

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Agenda

• VBP basics quick review
• Service delivery
  – Care management
  – Data-driven QI
  – Integration
  – Partnerships
• Infrastructure needs
  – HIT
  – Financial/Operational
  – Policies and Procedures
• Getting from here to there
• Strategic options
VBP BASICS QUICK REVIEW
Key elements of value-based payment models

- Payments are not based on service volume
  - Based on the population’s size and characteristics
  - Volume and productivity still matter
- Payment is not limited to billable encounters traditionally reimbursed on the fee-for-service schedule
- Rewards for reaching performance measures
  - Care cost
  - Care process
  - Care outcome
  - Structural changes
  - Consumer satisfaction/perception of care
NYS DOH’s view

**Current State**
*Increasing the value of care delivered more often than not threatens providers’ margins*

**Future State**
*When VBP is done well, providers’ margins go up when the value of care delivered increases*
The promise

• The work you do impacts 55% of the expected health outcome of the people you serve
• You’re not even getting 10% of the money
• The skills you’ve developed over the last fifty years are precisely the skills the medical system has figured out it needs
• This is your moment—*if* you seize it
SERVICE DELIVERY
Practice Transformation without a financial model is not sustainable.
A Financial model

*without a*

high value, comprehensive population management model of care

*is not*

sellable...or productive.
Care management: Purpose

Encourage more personal responsibility so that consumers become more active participants in their own health and more efficient users of the health care system.
Care management: Objectives

- Enhance access to primary and preventive care
- Coordinate the delivery and management of care across the continuum
- Promote the use of home and community-based long term care services to facilitate independence and enable clients to remain living in the least restrictive setting
- Prevent, delay or minimize chronic disease, functional deterioration and progression of disability
Care management: Objectives

• Involve clients, their care givers and providers in care planning and management

• Support primary care providers through data, information, analytics, and care coordination resources

• Improve health outcomes and member satisfaction at a reduced cost with a positive return on investment
Care management components

- Health risk assessment
- Risk stratification
- Care Plan development
- Coordination of care and services
- Monitoring and reassessment
- Outreach, especially to attributed clients you have never seen or who have disappeared
Evidence-based characteristics of successful care management programs

• Frequent in-person meetings with client plus telephonic contact

• Occasional in-person contact with PCP
  – CM assures PCP has all key external data

• Provide evidence-based education using motivational interviewing and behavioral-change techniques

• Strong medication management

• Timely and comprehensive transition of care including direct client contact
Data-driven QI

- Store, retrieve, calculate and report on clinical quality metrics
- Review clinical/quality outcome measures with clinical leadership and clinicians
- Use quality reports to inform outreach
- Use client data from payers with program data for reporting, retrospective analysis and CQI
  - Data warehouse
Data-driven QI

• Provider alerts and decision-support tools
  – Evidence-based protocols and decision-support tools embedded in the EHR
    • Reminders re preventive services
    • Flags re open loops
  – Alerts re hospital/ER utilization
  – Workflows to act on data re admission, discharge or transfer
• Real time executive dashboards
Client-centered care data

- Client satisfaction surveys (e.g. CAHPS)
- Client portal
  - Records
  - Appointments
  - Clinical questions
- Shared decision making/decision support tools
- Client visit cycle time
- Access metrics
  - Third next available appointment
  - Provider of choice
Client-centered care

• Triage
  – Both during and after operating hours
• Care coordination
• Telephone consultation
• Evening and weekend hours
• Same day appointments
  – Urgent and non-urgent
• Cultural and linguistic competency
  – CLAS standards
Integration: SAMHSA’s Six Level Framework

Coordinated
- Level 1: Minimal Collaboration
- Level 2: Basic Remote Collaboration

Co-Located
- Level 3: Basic On-Site Collaboration
- Level 4: Close On-Site Collaboration

Integrated
- Level 5: Approaching Integration
- Level 6: Transformed Integrated Practice
Persons with serious mental illnesses could be served in all settings. Plan for and deliver services based upon the needs of the individual, personal choice and the specifics of the community and collaboration.
Integration

- Routine medical screening
- A medically trained staff person is part of the care team, on-site and able to confer with the team throughout the day
- Same day visits for medical referrals
- Shared medical record with primary care
- Time set aside for case conferencing
Partnerships/agreements

• Identify what other service providers are providing care to your clients
  – Establish collaborative relationships and data sharing agreements

• Full range of medical services
  – Hospitals
  – Home health
  – Skilled nursing
  – Long term care

• Social services providers
  – Housing
  – Education
  – Child welfare
  – Supported employment
  – Correctional
HEALTH INFORMATION TECHNOLOGY
The Accountable Care Capability Framework:
A disciplined approach to IT gap analysis and strategic planning for value-based care

Aims of Value-Based Delivery Systems

- Improve the health of the population
- Bend the curve (control costs)
- Improve patient experience

Domains of information technology impact in health care

- **Information Management**
  - Organized
  - Findable / Available
  - Supports apps

- **Workflow Support**
  - “Right care” support
  - Efficiency, effectiveness

- **Financial Management**
  - Charges, collections, revenues, allocations
  - Cost knowledge and allocation

- **Analytics**
  - Data visualization
  - Prediction
  - Strategy support (mining, modeling)

- **Client Empowerment**
  - Consumer apps
  - Price and quality transparency
  - Advanced access

Business Functions

- Population health management
- Person-centered care management
- Clinical services
- Benefit management
- Competency assessment and management
- Relationship management
- Administra
- Planning

IT Management Functions
## Business Functions

<table>
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<tr>
<th>Population health management</th>
<th>Person-centered care management</th>
<th>Clinical services</th>
<th>Relationship Management</th>
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| - Member assessment: medical, social  
  - Health risk stratification and predictive modeling  
  - Empanelment and panel management  
  - Engagement of empaneled patients | - Care plan development  
  - Care coordination including care transitions  
  - Care management (medical and other services)  
  - Referral coordination  
  - Medication management | - Order management  
  - Service scheduling and access management  
  - Encounter information capture / documentation  
  - Data analytics and decision support (real time)  
  - Client decision support | - Customer service - members  
  - Customer service – network providers |
Business Functions (Cont.)

**Competency Assessment and Management**
- Training and competency development
  - Clinicians
  - Other staff members
- Competency assessment

**Benefit Management**
- Utilization management including pharmacy
- Referral and service authorization management

**Administration**
- Management and governance
- Member intake and management
- Provider network management
- Provider compensation mgmt
- Member incentive mgmt
- Resource mgmt (personnel, supply chain, facilities, equipment, external services)
- Finance and accounting
  - Receivables
  - Payables
  - Cost accounting

**Planning**
- Strategic planning
- Operational planning
- Budgeting
Information exchange is foundational. Having the information is not enough...

• In a value-base care environment, information exchange needs to be secure yet unencumbered for these (and potentially other) purposes:
  – Following up on events in a timely manner (e.g. ER and hospitalization alerts)
  – Identifying trends before they lead to unnecessary utilization (e.g. non-adherence to medications)
  – Understanding utilization patterns across all providers
  – Making complex and costly processes more efficient and evidence-based (e.g. referrals)
Data analytics

- EHR
- Registries/pre-visit planning
- Risk stratification
- Analytics
- Evidence-based decision making tools
- Care plans
Connectivity

- Health information exchange
- Telemedicine
- Remote patient monitoring
- E-consults
- Real time pharmacy data
- Real time alerts
FINANCE
What is value?

\[ V = \frac{Q \times S}{\$} \]

(Value) (Quality) (Service) (Cost)
Q: Quality measures

- Outcomes
- Savings generated
- Consumer satisfaction
- Preventive services/screening
S: Relative Value Units (RVU)

- The relative value for each service provided by a clinician
  - Part of the Medicare Resource-based Relative Value Scale
  - Three distinct parts
    - Clinician work component: time, skill and intensity associated with the service provided
    - Practice expense: direct and indirect expenses associated with provision of the service
    - Professional liability insurance: premium expenses
  - Geographic Practice Cost Index: 92 regions in the US
  - Multiplied by a conversion factor to translate into a fee
$: Total cost of care

- Cost per visit/cost per service
  - NOT cost per program
- Total annual cost per client
  - Stratified
  - By diagnosis
- Fixed costs and marginal costs
- Provider cost compared to value
Clinician compensation

• Align payments to your clinicians to the payments you will receive
  – Some portion based on RVU/productivity
  – Some portion based on value-oriented performance
    • Quality/outcomes
    • Client satisfaction
    • Efficiency
    • ‘Citizenship’
• Extrinsic factors
Getting there from here

• Time and staff resources
  – Map out clinical workflows
  – Map out fiscal workflows
  – Map out operational workflows
  – Negotiation with MCOs
• Financial position/cash reserves
• HIT infrastructure/support
  – HIE capability, willingness and agreements
• Liability/audit risk
• Clinician buy-in
• Board of Directors support
• Know your risk tolerance
Organizational leadership

Commitment to:

• Putting the needs of the clients first
• Venturing from the safety of the known
• New collaborations/integration with payers and providers
• Honestly assessing your ability to meet clinical targets and expectations
• Demanding delivery system and payment reform
Options for infrastructure: collaboration models

- **Independent Practice Association (IPA)**
  - Network of independent physicians or practices integrated clinically and/or financially

- **Physician-Hospital Organization (PHO)**
  - Joint venture between a hospital and physicians with admitting privileges at the hospital

- **Provider Sponsored Organization (PSO)**
  - A cooperative venture of a group of providers that takes on full risk for the lives of a set of beneficiaries.

- **Physician Practice Management Company (PPMC)**
  - Purchases individual clinical practices to which it then provides administrative support

- **Group Practice Without Walls (GPWW)**
  - Created when a number of small practices come together under a common tax ID number
Options for infrastructure: Management Services Organization (MSO)

- Provides Non-clinical Services for Individual Providers
- Economies of Scale and Cost Efficiencies

Range of Non-Healthcare Functions

- Administrative/operational
- Financial
  - coding
  - billing
  - collections
- Personnel
- Education/training
- Data collection and management
- Quality management
- Utilization management
- Facilities management
- Equipment
- IT
- Marketing
- Compliance
- Credentialing
- Purchasing
- MCO negotiation and contracting
- Strategic planning assistance
NEXT STEPS
Things you can do right now

- Educate and engage your Board
- Organizational analysis
  - Calculate the value you currently provide
    - Quality metrics
    - Total costs of care
    - Productivity
  - IT gap analysis
  - Partnership assessment
  - Service model transformation preparation
    - Primary care integration
    - Provider buy-in
- Strategic planning
- Baby steps
Accountability and risk go together

Provider Financial Risk

Level 0
- Fee For Service
- Incentive Payments
- Pay for Performance (P4P)

Level 1
- Bundled/Episodic Payments

Level 2
- Upside Shared Savings

Level 3
- Two Way Shared Savings
- Partial Capitation
- Full Capitation

Provider Integration and Accountability
Strategic options

• Become part of a large BH entity
  – BH provider IPA
  – Merger

• Become the BH component of an accountable entity
  – Leverage your PPS relationships
  – Integrated IPA

• Begin strengthening ties to MCOs
  – Pilots
Man cannot discover new oceans unless he has the courage to lose sight of the shore.

-André Gide