Embracing Evidence-Based Practices & Analytics To Thrive With Value-Based Care Models

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Agenda

I. The Market Shift Towards Value-Based Purchasing

II. Implications For Provider Organizations

III. Evidence—Based Practices (EBPs) & Analytics As Tools For Success
I. The Market Shift Towards Value-Based Purchasing
The Drivers Of Value-Based Payment

**The Affordable Care Act** Under reform, higher proportion of population insured, with no preexisting condition or lifetime limit exclusions – changing the population previously insured

**Health Care Cost Distribution** High-needs, complex consumers are 5% of the population and use 50% of resources – changing the distribution of spending in the population

**“Integrated” Care Coordination** Integrated approaches to health management increasing to improve health outcomes and reduce total costs
What Is Best Practice In Integrated Care Coordination?

Old Model:
- Medical
- Behavioral
- Social

New Model:
- Medical
- Behavioral
- Social

Value-based reimbursement models needed to optimize integrated care coordination.
# More Managed Care In The Health Care Landscape

## U.S. Managed Care Penetration By Payer, 2016

<table>
<thead>
<tr>
<th>Payer Segment</th>
<th>Total U.S. (Million)</th>
<th>Percent U.S. Population</th>
<th>Managed Care Enrollees (Million)</th>
<th>Percent In Managed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>56.5</td>
<td>17.5%</td>
<td>17.3</td>
<td>30.5%</td>
</tr>
<tr>
<td>Medicaid*</td>
<td>72.4</td>
<td>22.4%</td>
<td>45.4</td>
<td>62.7%</td>
</tr>
<tr>
<td>Military</td>
<td>4.8</td>
<td>1.5%</td>
<td>4.8</td>
<td>100%</td>
</tr>
<tr>
<td>Commercial</td>
<td>160.5</td>
<td>49.7%</td>
<td>159.0</td>
<td>99.1%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>28.6</td>
<td>8.9%</td>
<td>0.0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>323.0</strong></td>
<td><strong>100%</strong></td>
<td><strong>226.5</strong></td>
<td><strong>70.2%</strong></td>
</tr>
</tbody>
</table>

*Medicaid enrollment includes the Medicare/Medicaid dual eligible population*
Increasing Use Of Accountable Care Organizations

Currently, there are over 800 public and private ACOs in all 50 states, the District of Columbia, and Puerto Rico

- 436 Medicare ACOs
- 316 Commercial ACOs
- 62 Medicaid ACOs

25-31 million Americans (17% of the population) receive care through ACOs

- 2.4 million in Medicare ACOs
- 15 million non-Medicare patients in Medicare ACOs
- 8-14 million patients of non-Medicare ACOs

67% of Americans live in an area with ACO coverage
Transition Of Payment To Provider Organizations From Volume To Value

Compensation Continuum By Level Of Financial Risk

In 2014, about 40% of commercial health plan reimbursements to provider organizations were linked to value-oriented initiatives.²
What Are The Pay-For-Value Reimbursement Options For Provider Organizations?

- Case rates and bundled rates
- Medical homes and specialty medical homes
- Capitation and/or population health gainsharing arrangements

With Pay-For-Performance Components

Specialist positioning

Comprehensivist positioning
## Case Rates, Bundled Rates, & Episodic Payments

### Case Rates

Payment of a flat amount for a defined group of procedures and services

<table>
<thead>
<tr>
<th>Per treatment episode</th>
<th>Per time period</th>
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</thead>
</table>

Based on:

- Diagnosis or functional status
- Other consumer characteristics
- Package of services included
- Length of time
# Capitation in Population Health Arrangements

## Capitation/Subcapitation

A contracted rate for each member assigned, known as the "per-member-per-month" (PMPM) rate

<table>
<thead>
<tr>
<th>Regardless of the number or nature of services provided</th>
<th>Contractual rates are usually adjusted for age, gender, illness, and regional differences</th>
</tr>
</thead>
</table>

## Population Health Capitation

<table>
<thead>
<tr>
<th>Behavioral Health Carve-Out Capitation</th>
<th>• PMPM for behavioral health treatment benefits (or other cognitive disability support services)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Home/Health Home Capitation</td>
<td>• PMPM to cover the cost of care coordination and preventative services</td>
</tr>
<tr>
<td>Primary Care Capitation</td>
<td>• PMPM for primary care services (assess, prescribe, refer)</td>
</tr>
<tr>
<td>Global Capitation</td>
<td>• PMPM for cost of delivering all (or some) of the care for a group of consumers</td>
</tr>
</tbody>
</table>
Pay-For-Performance Or P4P

Payment systems that offer financial incentives based on achieving particular performance measures

- Focus on specified quality, cost and other benchmarks
- Incentives paid for to achieve, improve or exceed performance benchmarks
- Can be applied to any payment system – FFS, case rates, capitation

Typical P4P criteria

- Hospital readmission rate
- Emergency room utilization
- Continuing of care via follow-up after inpatient treatment
- Tenure in the community
- Access to care – in days to request
- Consumer engagement and treatment plan/medication adherence
- Reduced overall health care spending
Where Are We On The Road To Value-Based Reimbursement?

Medicaid health plans pushing ‘value’ down to the delivery system

38 state Medicaid programs that use at-risk capitated contracts with managed care organizations

16 states, 42%, include some kind of requirement for the MCOs to reimburse provider organizations using APMs

In addition, four states have plans to include APMs in the future
Where Are We On The Road To Value-Based Reimbursement?

Medicaid LTSS funding moving to managed care

9 million people receiving services under LTSS each year for $152 billion annually – elderly, physically disabled, consumers ‘at risk’ of nursing home stay, consumers with I/DD

1.2 million beneficiaries (13.3% of LTSS population) in managed care initiatives

LTSS either added to current Medicaid MCO or via separate MLTSS health plans
Where Are We On The Road To Value-Based Reimbursement?

Medicaid/Medicare dual eligible funding moving to managed care

525,715 beneficiaries (5.3%) of the 10 million dual eligible population, spending $294.4 billion annually now in managed care programs

States participating:
California, Colorado, Illinois, Massachusetts, Michigan, Minnesota, New York, Ohio, Rhode Island, South Carolina, Texas, Virginia, and Washington
Where Are We On The Road To Value-Based Reimbursement?

Medicare making transition to ‘value’

- Medicare moving 50% of $28 billion budget moved to APMs by 2018
- Medicare Advantage – 17.6 million enrollees, 31% of Medicare population
- Medicare Advantage SNP – 2.1 million enrollees, 3.7% of Medicare population
- Medicare ACOs – 7.7 million beneficiaries included, 13.7% of Medicare population
- Medicare Bundled Rate Program – 130,000 beneficiaries affected annually for joint/knee replacement; 1,600 participating provider organizations
- MACRA – 600,000 clinical health care professionals to be included on January 1, 2017
Where Are We On The Road To Value-Based Reimbursement?

Relationship between “managed care” and “provider organizations” is changing significantly

Health plans moving to gainsharing partnerships with provider organizations:

- ACOs risk sharing
- “Centers of Excellence” contracting
- Case rates and bundled rates – addiction treatment, chronic condition management, medical homes/health homes
Where Are We On The Road To Value-Based Reimbursement?

Recognition of the role of behavioral health and social services in population health management

5% of Americans consume half of all health care resources – more than 80% of have a comorbid behavioral disorder.

Behavioral health condition increase average health care costs by up to 200%

Presence of behavioral disorder increases chances of hospital admissions by up to 300%

High proportion of readmissions due to ‘social support’ factors.
II. Implications For Provider Organizations
### The Opportunities For Providers Are Many. . . .

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Behavioral health service system sub-capitation</td>
<td></td>
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<tr>
<td>Specialty care coordination for consumers with behavioral disorders</td>
<td></td>
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<tr>
<td>Specialty ‘center of excellence’ programs for acute conditions</td>
<td></td>
</tr>
<tr>
<td>Behavioral health consultation in office-based service locations – live or via telehealth</td>
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<tr>
<td>Management of specific acute episodes or chronic conditions via case rate or episodic/bundled payment</td>
<td></td>
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<tr>
<td>Management of short-term inpatient psychiatric and addiction treatment programs</td>
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<tr>
<td>Psychiatric consultation – live or via telehealth – in hospital emergency rooms</td>
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<tr>
<td>Behavioral health consultation program for inpatient programs – live or via telehealth</td>
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<tr>
<td>Hospital diversion programs</td>
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<tr>
<td>Specialty behavioral health ER/crisis stabilization</td>
<td></td>
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<tr>
<td>Hospital readmission prevention programs</td>
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<tr>
<td>Community-based/mobile crisis response</td>
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<tr>
<td>Home-based service delivery</td>
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<tr>
<td>Specialty primary care</td>
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On The Increase

• Tech-enabled, hybrid service delivery – BYOD in any location
• Programs with superior consumer experience, including web-enabled organization interfaces
• Professional “lifestyle” practices
• “Top of practice” delivery models
• Decision support and process excellence
• Any service – medical, behavioral, social – with demonstrated ROI and VBP reimbursement
• Case rate/bundled rate service programs for acute and chronic conditions

On The Decrease

• Provider organizations with poor consumer interface (access, experience)
• High unit cost services without ‘value’ equation
• Long-term outpatient services except in EBP
• Hospital and residential treatment, overall
• Office-based services without tech-enabled consumer link
• Solo practice, except for cash
Business Model Transition For Provider Organizations

**Payer Policy**
Pay-For-Cost/Volume

**Business Model**
What is paid for is good for the consumer and doing more is the business model

A revolution in performance management required

**Payer Policy**
Pay-For-Value

**Business Model**
Giving the consumer (and their payer) good outcomes at a low cost, conveniently
Implications Of Transitioning From Volume To Value Payments For Provider Organizations

- Develop organizational competencies and culture to compete in a performance-based world
- “Braid” health and social funding to achieve cost effective outcomes
- Improve understanding of cost drivers – administrative, clinical, and in population resource use
- Strengthen financial position and financial management capabilities
- Prepare for “narrowing” of provider networks due to risk-based contracts
How To Maintain Competitive Advantage & Financial Sustainability? Three Strategic Questions

What is your organization’s “vertical strategy” to engage emerging consumer care coordination organizations and consolidation among purchasers?

What is your “next generation” service line?

How does your organization create that “next generation” service line and stay a market leader?
Key Technology Functions To Improve Consumer Behavioral Health Treatment

- Identifying consumers in the population with significant risks
- Identifying optimal interventions for those consumers
- Timely cross-systems data integration to produce performance data analytics
Timely Cross-Systems Data Integration To Produce Performance Data Analytics

Coordinated care management solutions require access to in-depth patient information beyond traditional care boundaries.

Data integration should include physical and behavioral health, pharmacy, social determinants of health, and other factors that impact one’s wellbeing.

Data must be timely in order to positively affect care management.
Identifying Consumers In The Population With Significant Risks

Risk stratification is most effective when it is informed by longitudinal patient data across many dimensions.

Risk stratification tools store and analyze individual-level data and then aggregate that data for population-level analysis.

Effective risk stratification should predict future utilization patterns to identify those individuals at most risk of future disproportionate costs.

Risk stratification enhances care coordination by allowing for specific assignment of appropriate preventative and disease state management interventions.
Patient risk stratification and identification of care gaps & health improvement barriers helps to match each individual with the most effective and appropriate treatment.\textsuperscript{23}

Analytics should also flag patients who are non-adherent to care plans for specific interventions\textsuperscript{22}

Connecting patients with optimal care interventions improves engagement and also assures the most effective resource allocation.\textsuperscript{21}
## Strategies for Using Technology To Optimize Behavioral Health System Performance

<table>
<thead>
<tr>
<th>Provider performance transparency and network optimization</th>
<th>Support of value-based reimbursement</th>
<th>Improvement of health plan ratings</th>
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**Performance management and decision support tools**
Performance Management Tools

Management tools can be designed to span all areas of organizational performance – clinical and financial.

At the management level, operational performance is tracked by providing timely actionable metrics on organizational performance.
Well-designed analytics can provide real-time monitoring of individual professionals and provider organization performance.

Aggregate analysis of provider network metrics – access, utilization, outcomes, and cost – allows for optimization of the behavioral health system.

Provider performance analytics can show which organizations are providing care consistent with evidence-based quality metrics.
Support Of Value-Based Reimbursement

Shifting to value-based reimbursement of provider organizations requires monitoring of both clinical and cost data.

Analytics should be flexible to support the wide array of financial reimbursement models – pay-for-performance, fee-for-service, case rates, bundled rates, and capitated arrangements.

Analytics should capture and analyze factors impacting system quality and outcomes – and perform cost-per-unit analysis to improve efficiency.
Improvement Of Health Plan Ratings

Health plan ratings are increasingly tied to health plan reimbursement.

Enhanced data management can integrate clinical and financial data from multiple system into a single, powerful resource that drives improved health plan performance.

The power of aggregated data is enhanced through actionable reporting which targets areas for strategic improvement of HEDIS and CMS STARS ratings.
III. Evidence—Based Practices (EBPs) & Analytics As Tools For Success
This gradual, but absolute shift is happening

Deploying, monitoring and reporting on EBPs and related outcomes will be required

A system that treats people mostly when they are sick or need treatment

Revenue based on VOLUME

= $\quad$

A system that PROACTIVELY manages the health of populations

Revenue based on VALUE

- Quality
- Efficiency
- Satisfaction

Clinical performance drives reimbursement
Human Services
Lags in Technology Adoption

Utilizes a Certified EHR

No Commercial System

ACUTE CARE

15%

85%

PRIMARY CARE

22%

78%

HUMAN SERVICES

50%

50%

Only 50% of Human Services uses a commercial EHR

Source: ONC Data Brief March 2013
Biggest, Identified Technology Gaps

As providers prepare for value-based care

#1 Interoperability

#2 Reporting/Analytics

Source: KLAS Survey
So the Market is Shifting... What is Required?

Automated and integrated methods of deploying **EBPs** and leveraging **data**

Agencies must ask new questions about **clinical** and **financial** data

Make the **right data** accessible to the **right people**, when and where it matters
Best Practice Use of Technology
For Thriving with Value-based Care

- Integration of “tools” into your core system
- Evidence-based Practices
- Data Analytics/Business Intelligence System

- Other Technology Considerations
  - Connectivity/Collaboration System that aggregates and parses data (Interoperability)
  - Care Coordination/Population Health Management that drives alerting within workflow
Single Sign-on for Disparate Systems…

- Reduces the number of passwords a user has to remember
- Provides convenience to the users
- BUT, information is not integrated
An Integrated Solution

- Clinical
- Financial
- Compliance
- EBP outcomes
- Workflow Optimization
- Data Capture Strategy
- Process Improvement
- Data Visualization

EHR Core System

- Evidence-based Practices
- Business Intelligence
- Population Health Management
CLINICAL ANALYTICS:
Integration of Evidence-based Practices
## Evidence-based Practices

### Clinical Analytics

<table>
<thead>
<tr>
<th>Needs</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>• EBP integration within EMR workflow</td>
<td>• Drives fidelity and application</td>
</tr>
<tr>
<td>• Daily or real-time updates available to clinical team</td>
<td>• Can’t improve what you don’t measure…Can’t improve what you don’t measure <em>and see!</em></td>
</tr>
<tr>
<td>• Output of EBP needs to be visualized in a manner that allows for clinical utility and both operational and clinical improvement</td>
<td>• Provides meaningful and contextually relevant information to the user by role</td>
</tr>
</tbody>
</table>
In this example our EBP focuses on four different measures.

1. Recovery Needs Level
   Staff assigns appropriate level of care

2. Recovery Markers Inventory
   Staff rating of consumer’s progress

3. Consumer Recovery Measure
   Consumer rating of his or her recovery

4. Promoting Recovery In Organizations (PRO SURVEY)
   Consumer rating of the organization’s recovery culture
Leverage technology to automate administration and tracking of EBPs. Identify and track entire caseload. Monitor performance on required assessments and metrics.

Ability to track and view EBPs from the EHR.
Recovery Measures and Outcomes
Contextually relevant and visualized

**CONSUMER RECOVERY MARKERS (CRM)**
Consumer’s perception of progress is available within the workflow, trended and visualized.

**RECOVERY MARKERS INVENTORY (RMI)**
Clinician’s assessment of progress is available to overlay within the workflow and drive meaningful dialogue.
Benefits of an Integrated Data Set:
The role of Analytics and Business Intelligence
Considerations for Using Analytics to Support VBC

• Requires business intelligence…not just reporting
  - Simple queries become easy to complete…aggregate then drill down
  - Equips leaders with the ability to articulate value proposition

• Interactive data visualizations are very helpful
  - Ability to modify without IT support
  - Create role relevant views

• Data gaps will be exposed in VBC models; will prove costly
  - Ex: Missing data elements in your process that are required to maximize bonus $ under VBC

• Approach must allow for the creation of cohorts (defined population)
  - Equips the organization to excel in tracking and exceeding quality measures for sub-populations
  - Allows for a data-driven presentation of your value proposition…move from anecdotal to factual
Flexibility to Identify Leading Indicators

Using information to view metrics that may affect other areas of the organization, for example denied claims.
Considerations
Different Data Needs Based on User Role

Examples:

- Create compliance view to ensure bonus payments on value-based care metrics
- Create views to exclude certain services for grant-funded programs so the CFO can get the right view of financial data
- Create views of unique visits over specific time periods for clients and cohorts...then calculate current revenue and project future revenue...model the what if
Ability to view KPIs from the EHR
Service vs. Rate-based Models

Avg. # Services per Client: 13

Avg. # Visits per Client: 10
Projecting the New Payment Method

Payment per Service: $78.19

CCBHC Daily Rate per Client: $125
Considerations on Stratifying and Measuring Within a Population

Value-Based Care

• Many existing models stratify and attribute the population for you

• Under VBC models you will need the ability to self-stratify
  – Cohorts can be developed by utilization patterns, disease states, medications, age, service program, etc.

• You will own the population and determine when, how and where the provision of care occurs
Comorbidity Sorter

Population with a Comorbid Diagnosis

Drilling down to the client level
Outcome/Cost-the End Game

Cohorts
- Diagnosis(s)
- Acuity Level
- Age
- Gender

Outcomes
- Reduced Hospitalizations
- Reduced Acuity Levels
- Recovery Markers Inventory
- Consumer Satisfaction
- Employment

Service Analysis
- Service Type
- Licensure
- Modality
- Frequency
Outcome/Cost-the End Game

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The Power of integrating EBP and Analytics

Trending of a defined population’s outcomes on your selected EBP over time
Conclusion

• Organizations that marry \textit{workflow + reporting} will have an opportunity to \textit{participate} in VBC models

• Organizations that create purposeful, role-based workflows to enable data visualization in an integrated way; \textit{and} marry their \textit{EBP + analytics/business intelligence platform} will be equipped to \textit{thrive} in VBC models
Turning market intelligence into business advantage

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Addiction Treatment ▪ Social Services ▪ Intellectual & Developmental Disability Supports
Child & Family Services ▪ Juvenile Justice ▪ Adult Corrections Health Care