PROMISE AND PERILS OF VBP

August 16, 2023

Presented By:
Meggan Schilkie
Vice President, Strategic Focus Areas
Health Management Associates

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DHCF
Department of Health Care Finance

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PRESENTER

Meggan Schilkie
Vice President, Strategic Focus Areas
Health Management Associates
mschilkie@healthmanagement.com

Link to Bio

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AGENDA

I. An overview of health impacts

II. What behavioral health providers need to be successful

III. Options for providers moving forward

Learning Objectives

1. Explain why the move to VBP creates an opportunity for BH providers
2. Describe how the move to VBP might undercut the existing business model of community BH agencies
3. Plan to take advantage of the opportunities of VBP while avoiding the worst possible outcomes.

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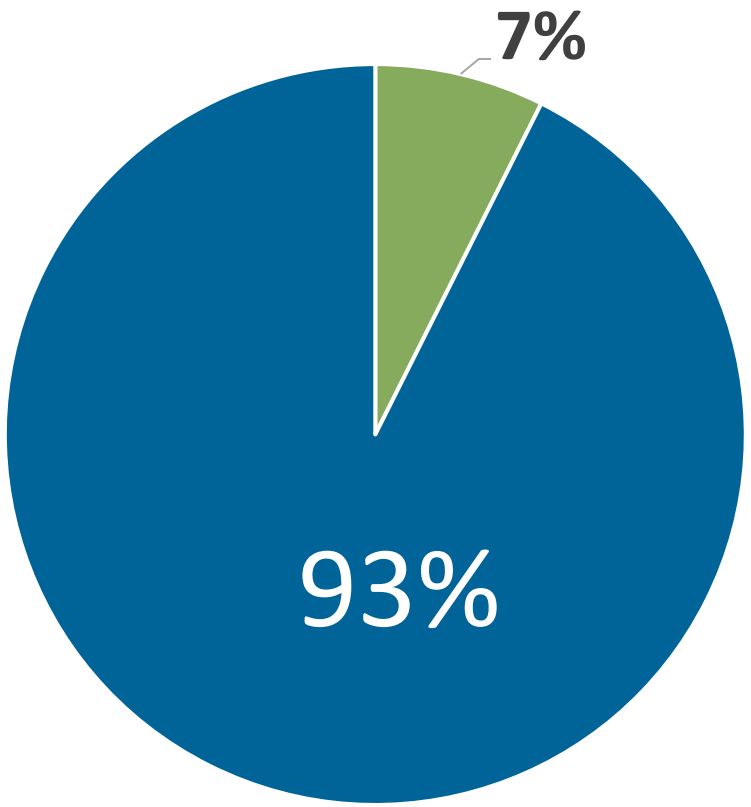
WHICH PIECE OF THE PIE LOOKS MORE FILLING?



Behavioral Health

Medical

Source: Mark T, Levit K, Yee T, Chow C. Spending on Mental and Substance Use Disorders Projected to Grow More Slowly Than All Health Spending Through 2020. Health Affairs, August 2014, 33:8,1407-1415.

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BIG QUESTION FOR BH PROVIDERS

How can you be part of an organization that has attribution, infrastructure, and scale in a way that enables you to access integrated medical care and human services for your clients, and provide BH care to a broader population, while maintaining your focus on the population about which you are most concerned?

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D.C. HEALTH MATTERS CONNECT (CONNECT) DATA

TOP 10 SDOH NEEDS	# OF SEARCHES
Emergency Food	491
Food Pantry	462
Help Finding Housing	432
Food Delivery	338
Help Pay for Utilities	270
Help Pay for Housing	237
Bus Passes	157
Temporary Shelter	143
Help Pay for Food	139
Housing Vouchers	137

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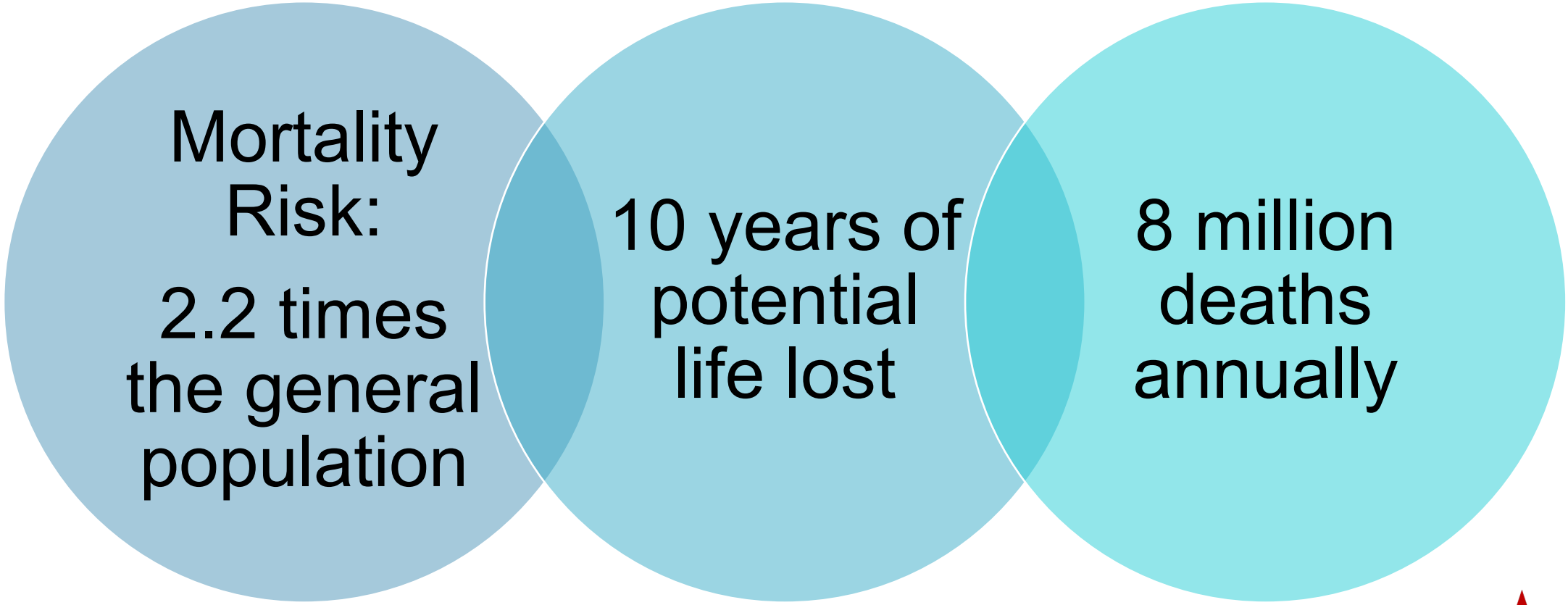
MENTAL ILLNESS AND MORTALITY



Source: Walker, E.R., McGee, R.E., Druss, B.G. *JAMA Psychiatry.* Epub, doi:10.1001/jamapsychiatry.2014.2502

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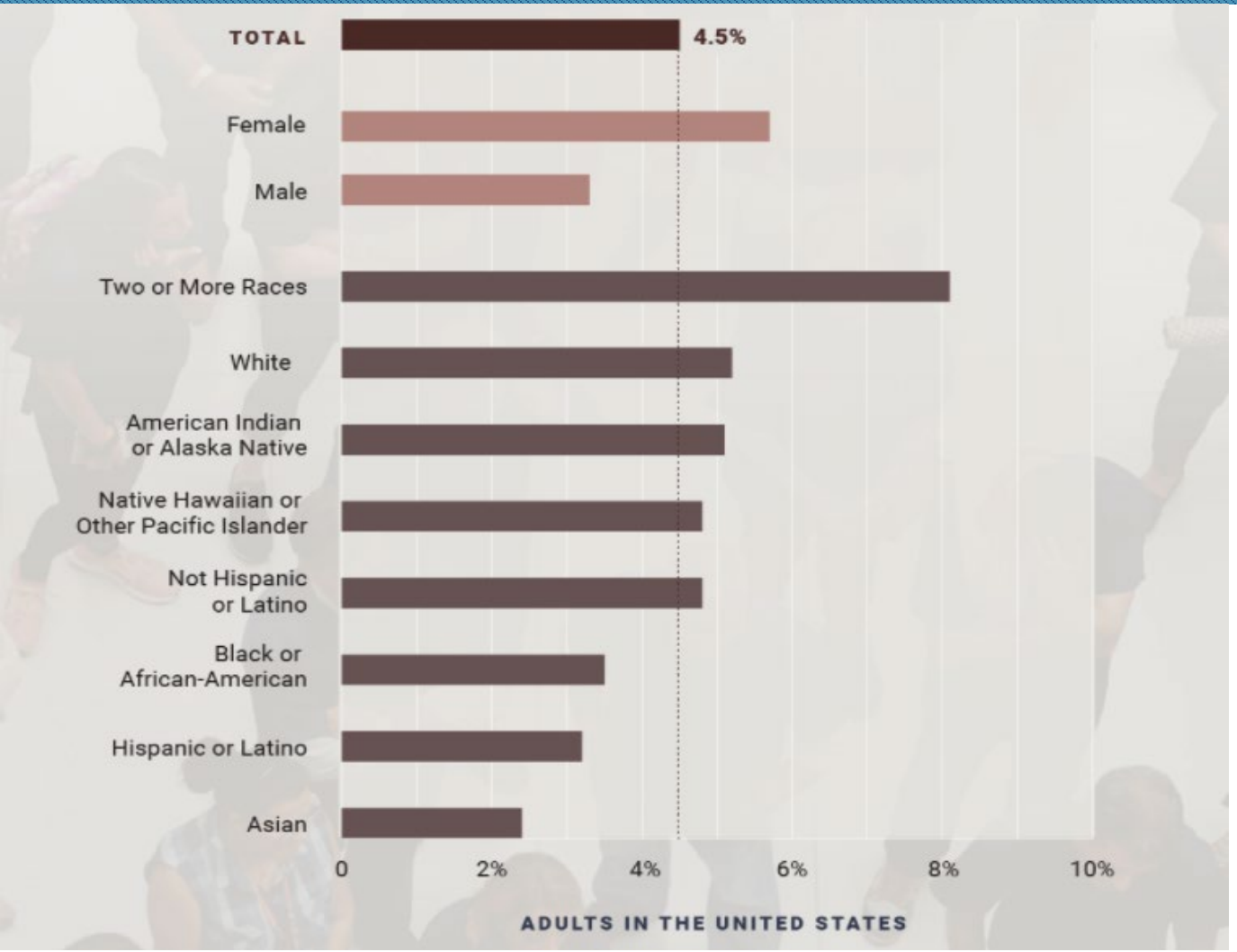
ADULTS LIVING WITH SERIOUS MENTAL ILLNESS



- People with SMD have an approximately one to three times higher risk of cardiovascular morbidity and mortality compared to the general population.
- People with schizophrenia and bipolar disorder have double the risk for diabetes compared to the general population while people with depression have 1.5 times the risk.
- Infectious diseases, including tuberculosis and hepatitis, appear to contribute to an increased risk of death in people with SMD, with a risk that is four to eight times greater than that of the general population.

Source: U.S. Department of Health and Human Services. "2017 National Survey on Drug Use and Health," Substance Abuse and Mental Health Services Administration. Accessed July 2, 2019. https://www.samhsa.gov/data/report/2017-nsduh-annual-national-report

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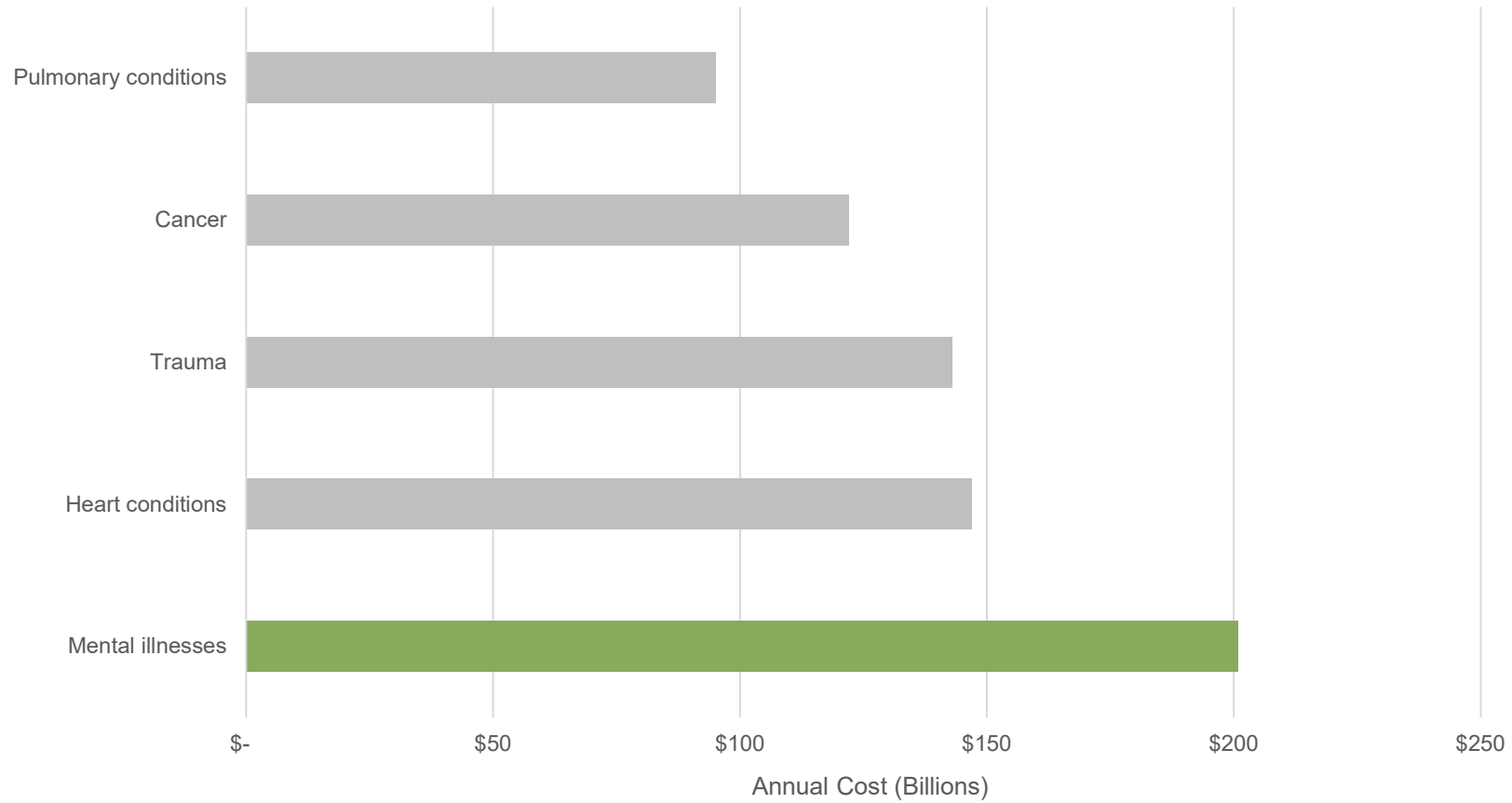
MENTAL DISORDERS ARE THE MOST COSTLY CONDITIONS IN THE UNITED STATES



Source: Roehrig C, Mental Disorders Top The List Of The Most Costly Conditions In The United States: $201 Billion. Health Affairs 35, no. 6 (2016) 1130 – 1135.
JAMA **Association of Mental Health Disorders With Health Care Spending in the Medicare Population**
https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2762948

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The Biggest Challenges Facing the Medical System Today

- Behavior Change
- Care management
- Social determinants of health
- Patient-centered, culturally competent care
- Outreach to difficult to engage populations

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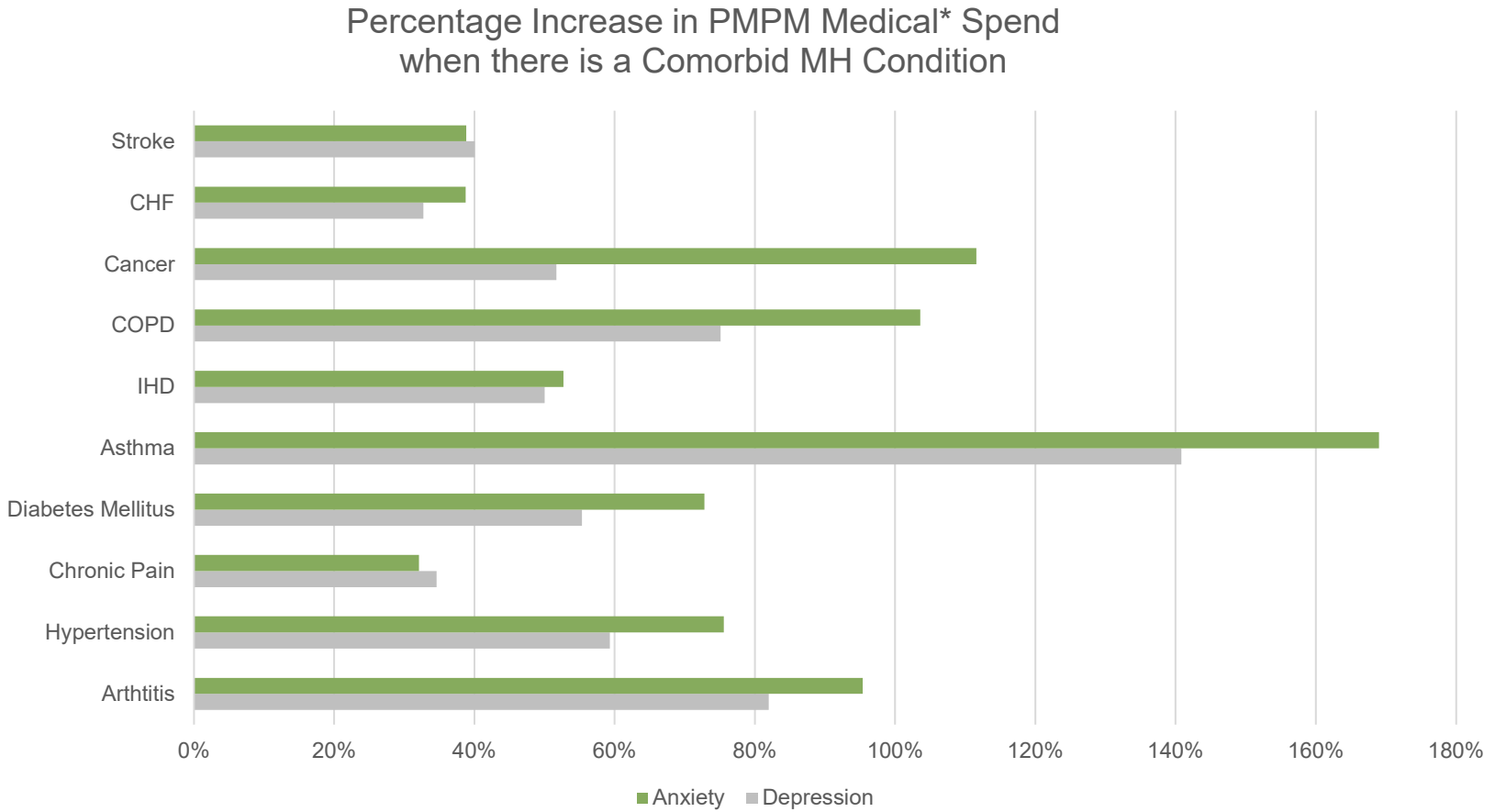
MENTAL HEALTH CONDITIONS INCREASE MEDICAL COSTS



*Note: Does not include any BH spend

Source: Melek S, Norris D. Chronic conditions and comorbid psychological disorders. Milliman Research Report. July, 2008.

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CHALLENGES AND OPPORTUNITIES

- COVID-19 has accelerated pace towards individualized, flexible services not reliant upon bricks and mortar
- Technology use and delivery of remote services has expanded during the pandemic
- Many states still working to develop person-centered practices and systems
  - Case management/supports coordination still evolving in many systems, including move to conflict-free
- States seeking solutions for people with BH and unmet social needs/ support needs
- Siloing of PH and BH services predicated on FFS system
- BH providers are often ill equipped to measure outcomes across a population
- Racial and cultural disparities are receiving more attention as states look to ensure equity and deliver culturally-responsive services

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THE PROMISE

- The work of the BH community impacts most of the expected health outcomes of the people we serve
- We're not even getting 10% of the money
- The skills we've developed over the last fifty years are precisely the skills the medical system has figured out it needs
- This is our moment— if we seize it

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VBP IS A MARKET BASED SOLUTION

- Competition
- The ‘invisible hand’
- Joseph Schumpeter
- What gets measured gets paid for
  - What gets measured is contested, complex and critical
  - How can we reduce the work of our community to a de Minimis set of performance indicators?

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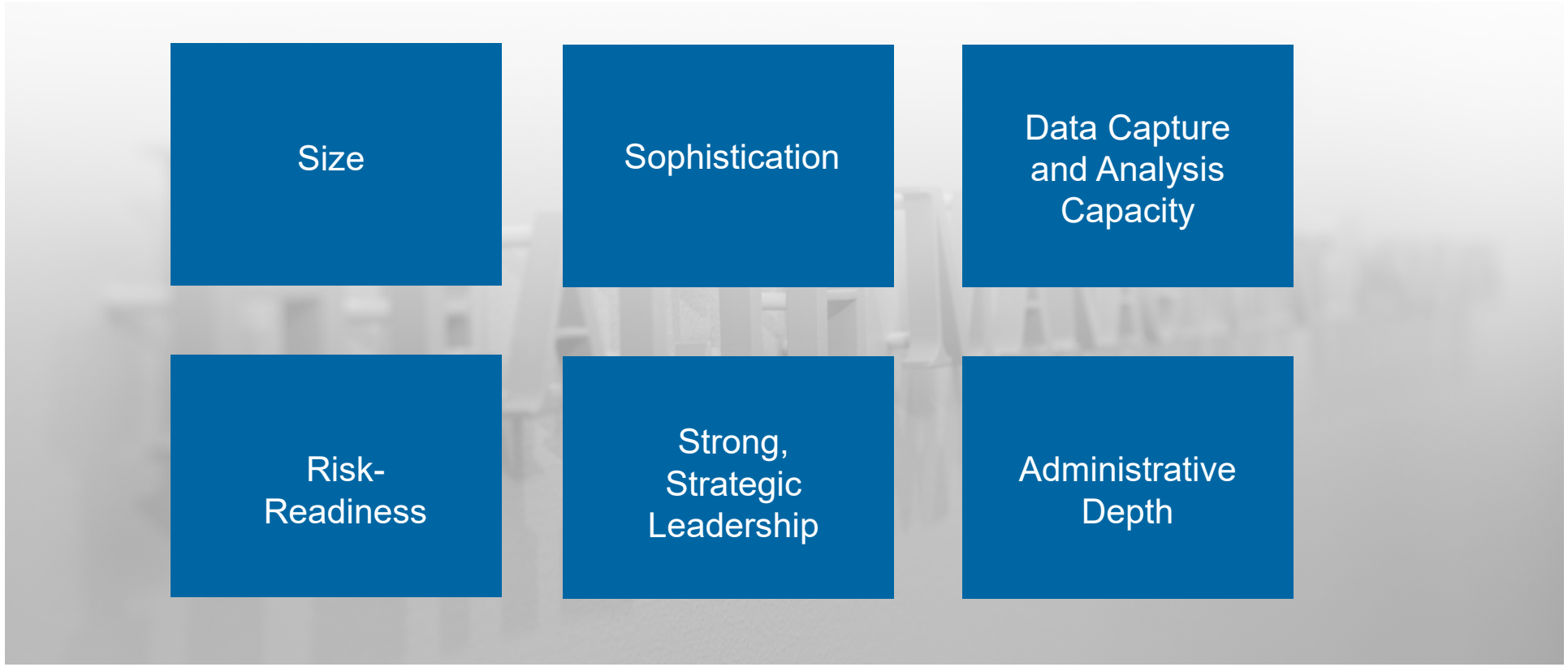
VBP ADVANTAGES PROVIDERS WITH CERTAIN CHARACTERISTICS



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CRITICAL STEPS TOWARD VALUE-BASED ARRANGEMENTS

- Internal HIT and analytics
- Meaningful partnerships
- Person-centeredness (accessible, culturally competent care)
- Culture of continuous quality improvement
- Ability to monitor costs, productivity and efficiency in near real-time
- Population-based strategies
- Sufficient volume

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IT IS NOT THE STRATEGY, IT ENABLES YOUR STRATEGY

VB Quality Measures cannot be easily or effectively calculated <u>without</u> electronic data

IT facilitates communication internally and externally…

Your IT systems could include a range of capabilities. At root it must include an EHR, but could be expanded to include a data warehouse and other analytic capabilities, to Bluetooth-capable scales and BP cuffs. What you need should be **aligned with your agency strategy.**

…with care providers INSIDE your agency

Identify and track high-cost consumers and ensure they are receiving high value care aligned with your value contracts

…with care providers OUTSIDE your agency

Exchange data with external provider to ensure care is effectively coordinated across institutional silos

…with Payers

Most payers require electronic submission of claims. Electronic coding can improve your coding efficiency, as well as how quickly your claims are paid.

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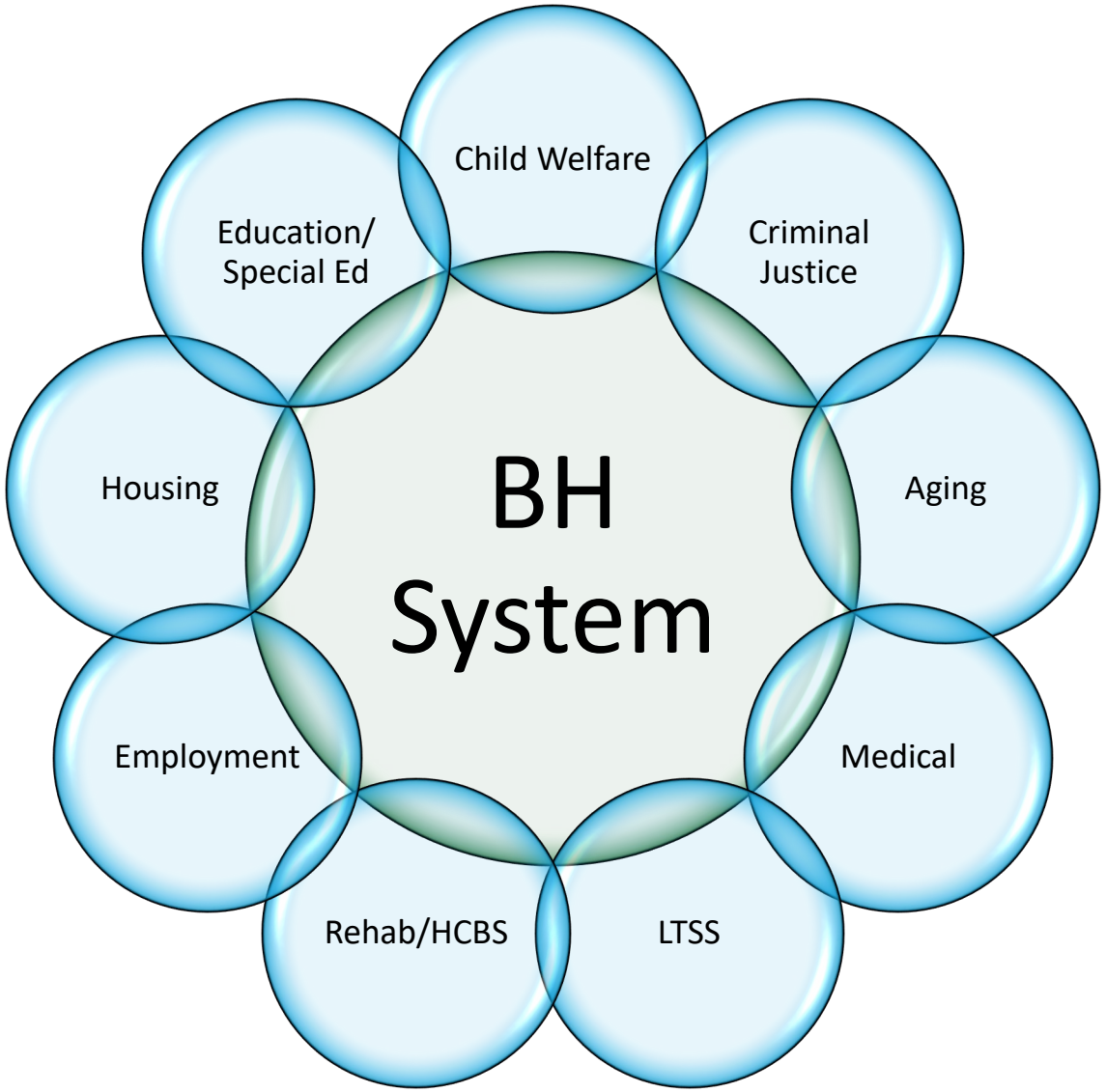
PARTNERSHIPS/AGREEMENTS

BH providers will need to provide services or have partnerships in place across multiple service systems



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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/ community supervision

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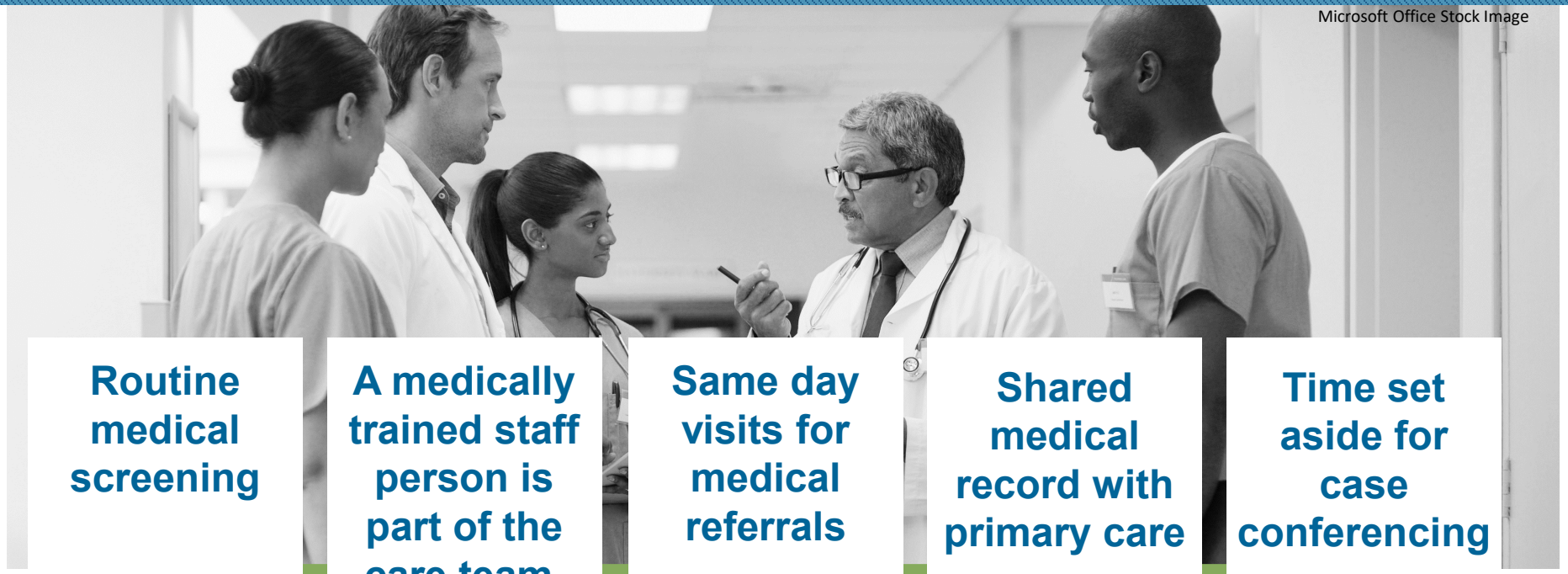
INTEGRATION



Microsoft Office Stock Image

- 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

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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

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$: 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**

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REGIONAL MCO CASE STUDY: CRISIS STABILIZATION UNITS (CSU) – OUTCOMES

- **21% reduction in length of stay** for extended stays, which allowed for a 35% increase in monthly capacity
- **85% of admissions in 2018 came from the emergency department** and avoided potential inpatient hospital, inpatient psychiatric, or external crisis unit admissions
- **90% of members at both locations rated their overall satisfaction as "good" or "excellent"** in satisfaction surveys
- Average costs for CSU admissions are $690 per member per day, versus average inpatient admission costs of $1,071 per member per day – **savings of 35.6%**

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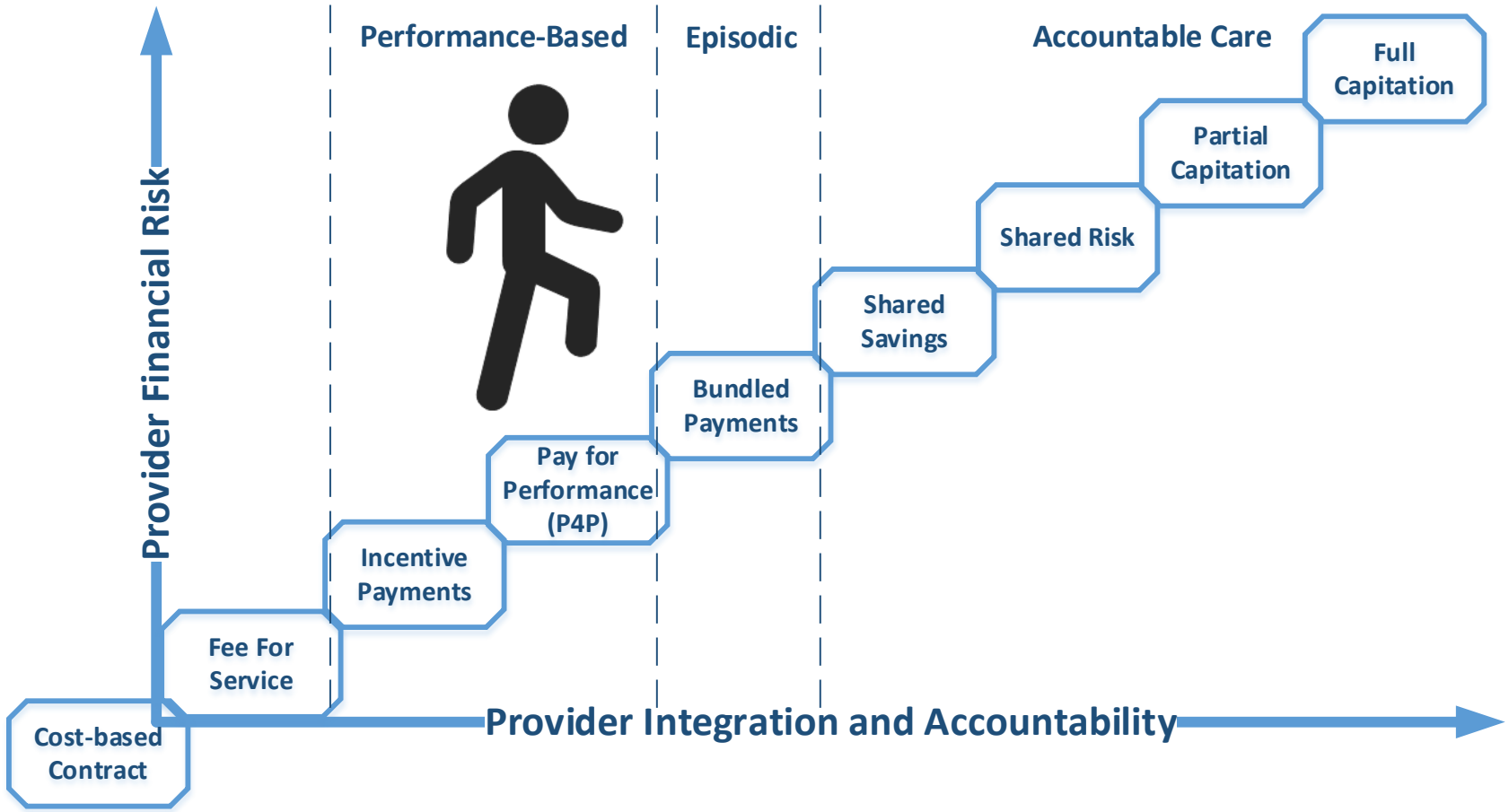
ACCOUNTABILITY, RISK AND INTEGRATION GO TOGETHER



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WHAT DO YOU NEED TO ACCOMPLISH THIS

- A culture of quality – collecting the data and evaluating programs as a matter of course
- Infrastructure to collect and analyze
- Access to Medicaid claims data
- Relationships with your payers and established structures and mechanisms for reviewing the data together
- Potential external funding (grant, government?) for external evaluator

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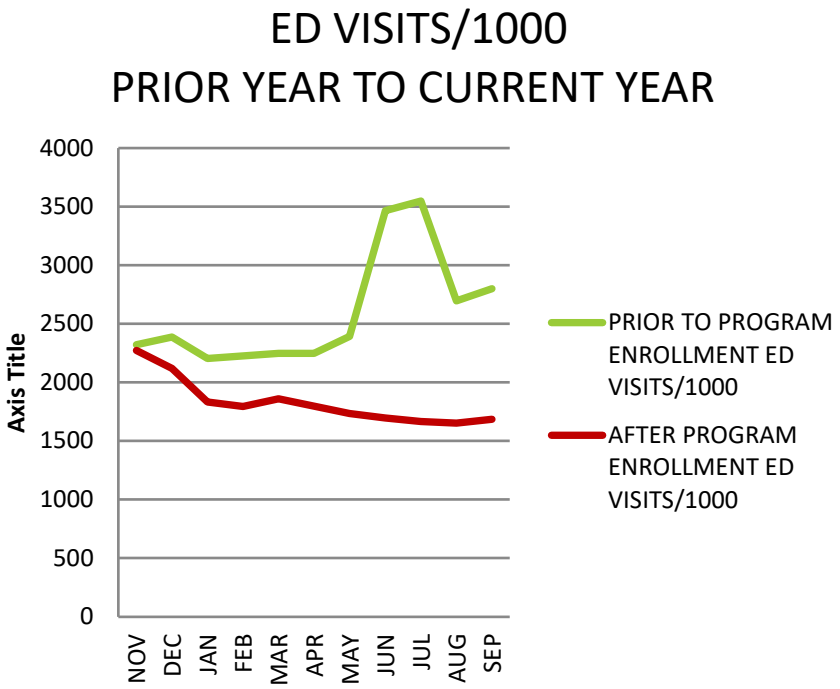
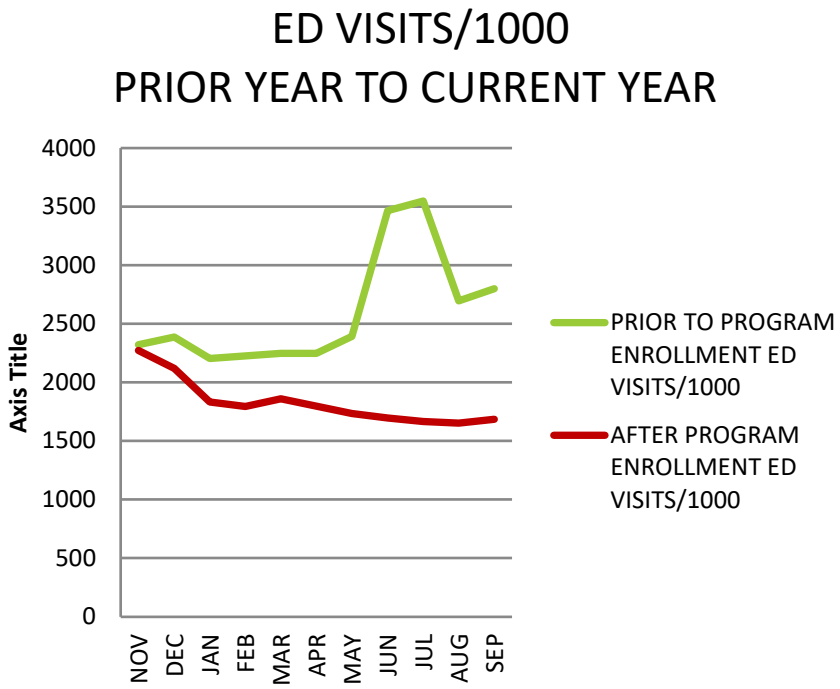
CASE STUDY: CONTRACT BTW. MCO AND FQHC (SUB TO IPA)

- Contract through Integrated IPA
  - BH-IPA has a sub-attribution for which they are responsible for TCoC
- For MCO members who receive primary care from partner FQHC
- Care management for individuals with BH diagnosis and co-occurring medical condition
- Metrics for which BH-IPA is responsible:
  - Health screenings
  - Diabetic Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications
  - ED Visits
  - Medications

TO DETERMINE PROVIDER POTENTIAL TO PERFORM ON SHARED SAVINGS, UNDERSTAND UTILIZATION: REDUCED UTILIZATION TRANSLATES INTO COST SAVINGS





MCO xx has provided utilization performance that indicates that provider xx is impacting utilization. The improvement should be discounted by about 20% for improvements that would have happened without coordination. Admissions were reduced by about 60%, which means there is still 40% improvement (200/k), although further validation would be needed from MCOs. At $3400 per admit, this translates into $680 per member per year ($56pmpm). A similar analysis could be done for ED visits, once the actual cost is determined.

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TO DETERMINE PROVIDER POTENTIAL TO PERFORM ON SHARED SAVINGS, UNDERSTAND UTILIZATION: REDUCED UTILIZATION TRANSLATES INTO COST SAVINGS

	Per Month	Per Year
Total Beneficiaries	2,000	2,000
Average estimated Total Cost of Care (TCOC) per member	$1,000 pmpm TCOC	$12,000 pmpy TCOC
• Average Estimated TCOC for provider's population	$2 million per month TCOC	$24 million per year TCOC
Current estimated cost of admissions	$142 pmpm admit cost	$1,700 pmpy admit cost
• Benchmark admit rate 500/k per year (total of 1k admission per year for provider's population) • $3,400 per admission	$285,000 per month Admit cost	$3.4 million per year Admit cost
Projected Reduction in cost of admissions	$42.50 pmpm savings in reduced admits	$510 pmpy savings in reduced admits
• Savings driven by 30% annual reduction, taking admit rate to 350/k per year (total of 700 per year for provider population) @ $3,400 per admission • New Cost of Hospital Admits = $2,380,000	$85,000 monthly savings in reduced admits	$1,020,000 Annual savings in reduced admits
Shared Savings Earning Potential for Provider		
• 25% provider split with MCO	$11 pmpm $21,250 per month	$127 pmpy $255k annual
• 50% provider split with MCOs	$22 pmpm $42,500 per month	$254 pmpy $510k Annual

A focus on the highest cost members is important

Other types of costs may be saved; certain costs may go up

Detailed methodology will need to be negotiated with MCOs;

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QUESTIONS THIS BEGS

- How many of you would it take to get to 2,000 people with one plan?
- If you bring it down to 500 clients each, then you're talking about $63-$68K/year
- Is it worth it?
- What could you do for $68K/year?
- Would it matter when you got it?
- If you are already doing this, then it is just about getting paid for what you're already doing…..how do you know?
- Do you know who the current highest cost individual that you serve is? What their TCOC is?

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SOURCES OF INCREASED REVENUE

Shared Savings : Managing Costs

MCOs are interested in managing costs to offset lack of funding for most expensive beneficiaries

Understand the Total Cost of Care or Sub-capitated Cost of Care for BH services only for the Provider's Population with an MCO

Number of Provider's Beneficiaries with MCO XX	Average pmpm costs
1	$62,500
1	$37,500
1	$29,167
4	$20,833
2	$12,500
4	$6,833
5	$5,167
14	$2,917
50	$1,333
512	$333
Total Members: 594	**Average pmpm: $957**

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SOURCES OF INCREASED REVENUE

Shared Savings : Managing Costs

By reducing the top person's average PMPM costs by just $30K, you reduce the average PMPM by $50…

Number of Provider's Beneficiaries with MCO XX	Average pmpm costs
1	$32,500
1	$37,500
1	$29,167
4	$20,833
2	$12,500
4	$6,833
5	$5,167
14	$2,917
50	$1,333
512	$333
Total Members: 594	**Average pmpm: $906.50**

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OPTIONS FOR FUNDS FLOW

1. **Distribution/administration of pay for performance bonuses and incentives (as well as penalties)**

2. **Shared savings distribution**
   -One to One/even distribution
   -Contribution to network (via attribution)
   -Cause/effect based on detailed pre-/post-analysis

3. **Deferred/Investment in Shared Costs**

4. **Fee-for-service PLUS (add-on for every processed claim)**

5. **Quality metrics pool**

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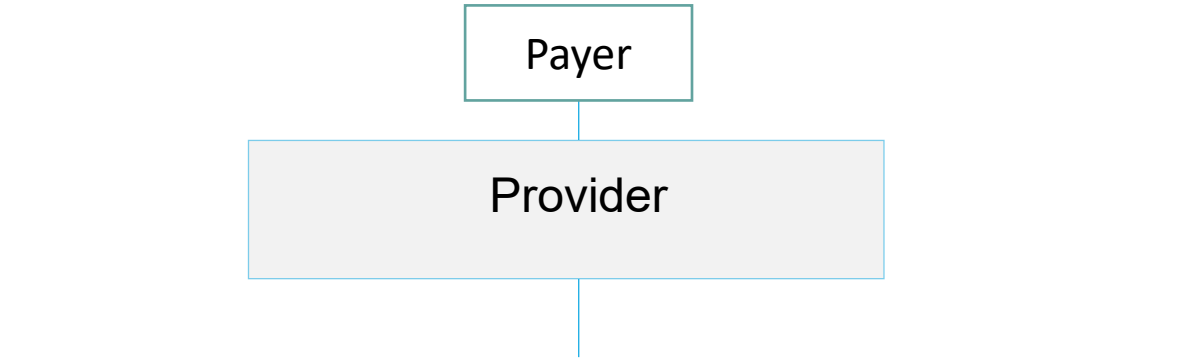
FUNDING MODEL

Funding Model

Three Funding Streams:

1. **Delegated** Care Management Fees
2. **Shared Savings**
3. **Pay for Performance**



Care Management

- Upfront Delegated CM Fees (Monthly)
  - Used to fund CM Staffing and Infrastructure
- Complex Care Included

Shared Savings to Shared Risk

- 50/50 sharing of savings between ACO and Plan
- Transitioned to Shared Risk after 3 years
- Stop-loss for high dollar cases from Plan

Pay for Performance

- Key Measures Associated with Plan Withhold or Quality Goals

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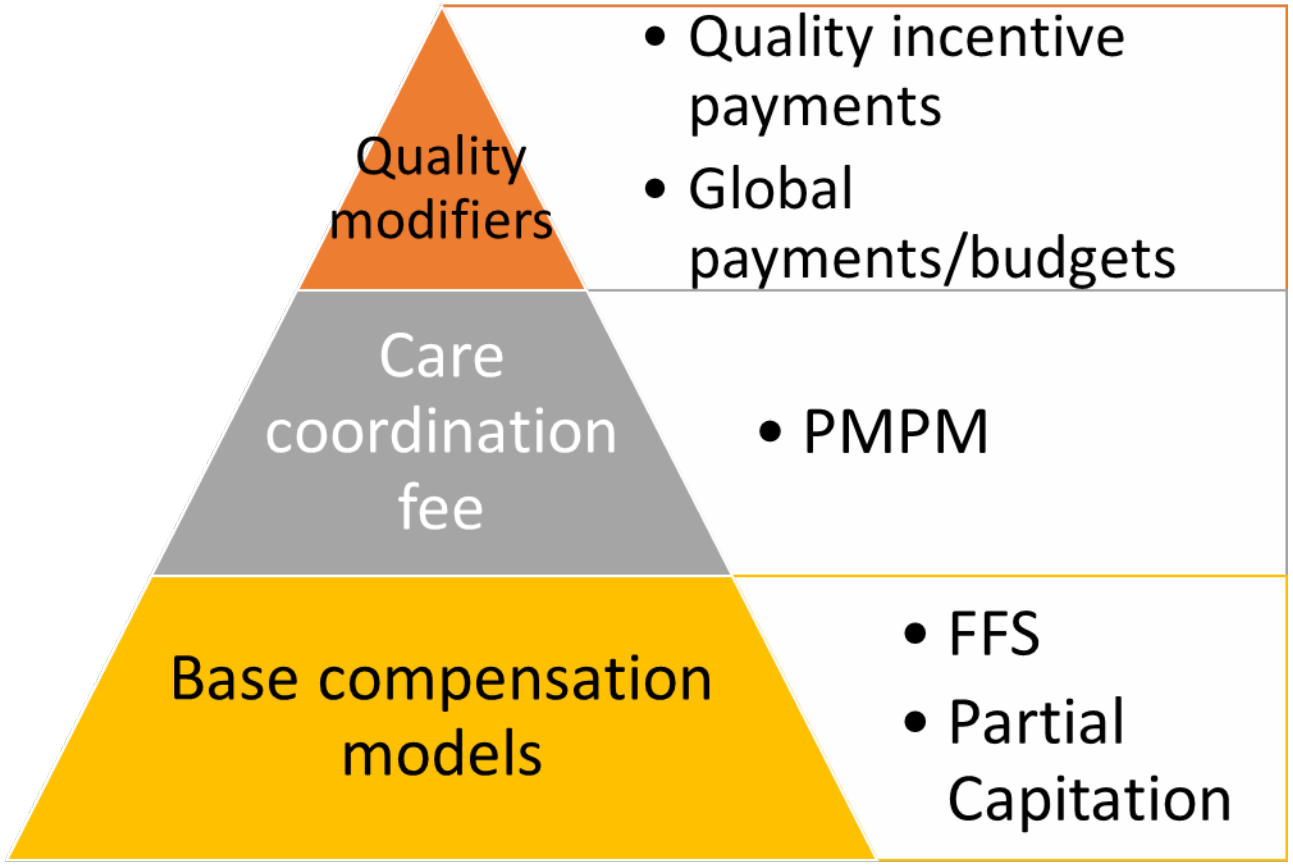
ANOTHER WAY TO THINK ABOUT VBP PAYMENT STRUCTURES



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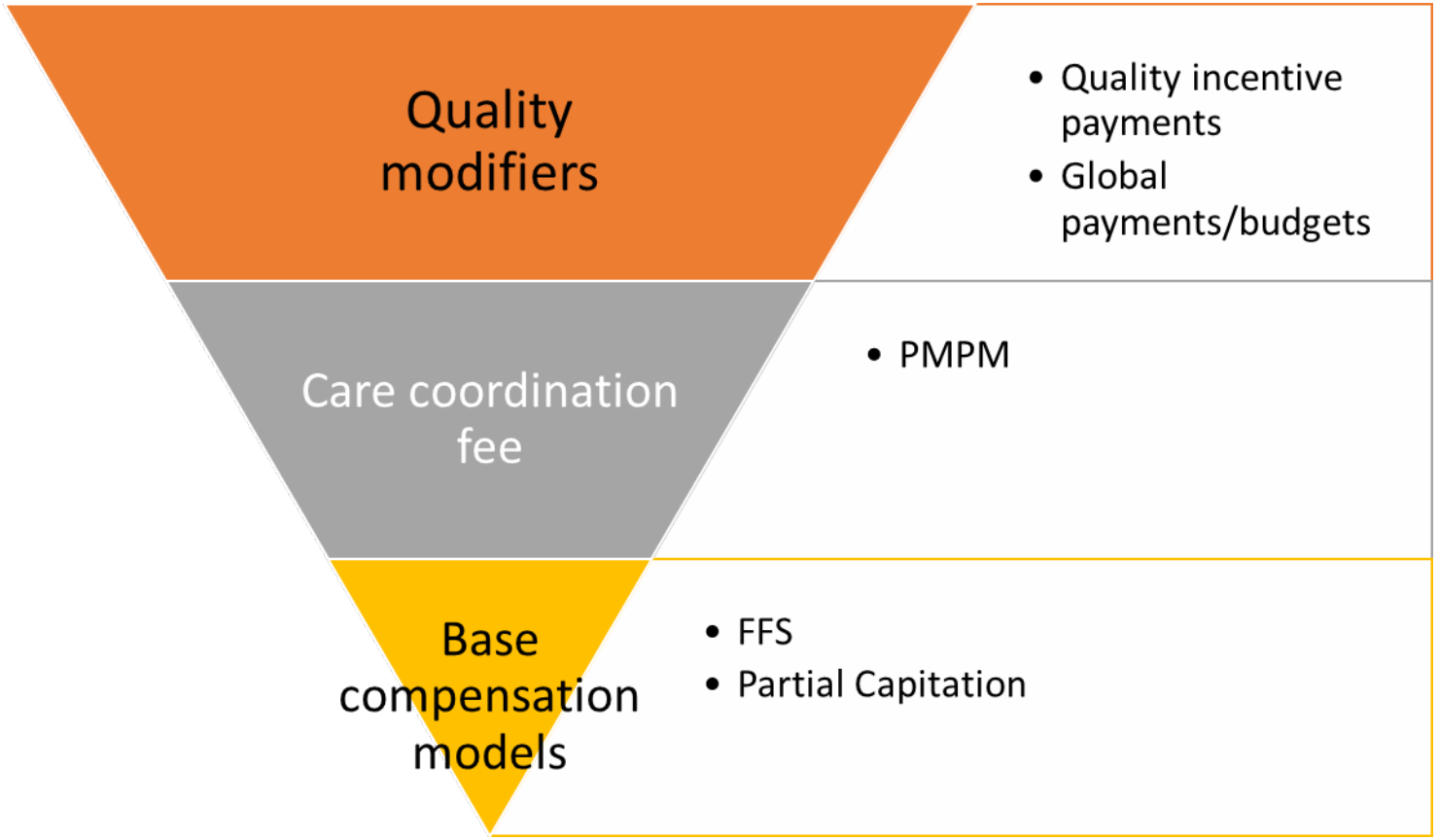
THE VISION IS TO FLIP THE PYRAMID



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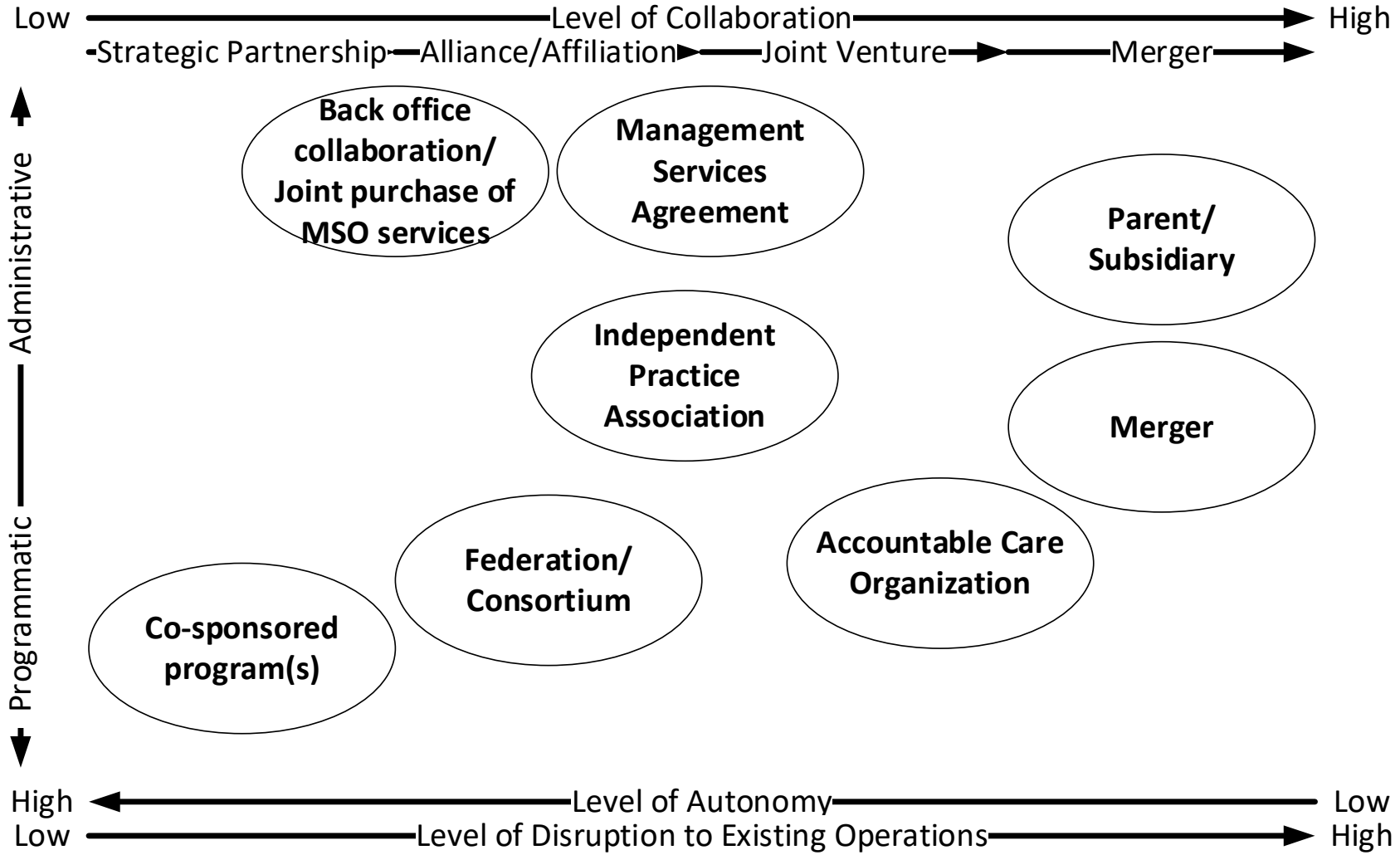
STRATEGIC PARTNERSHIP OPTIONS



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OPTIONS FOR BH PROVIDERS

- Be big
  - Vertical integration and expansion is necessary either directly through growth, via acquisition or by partnership

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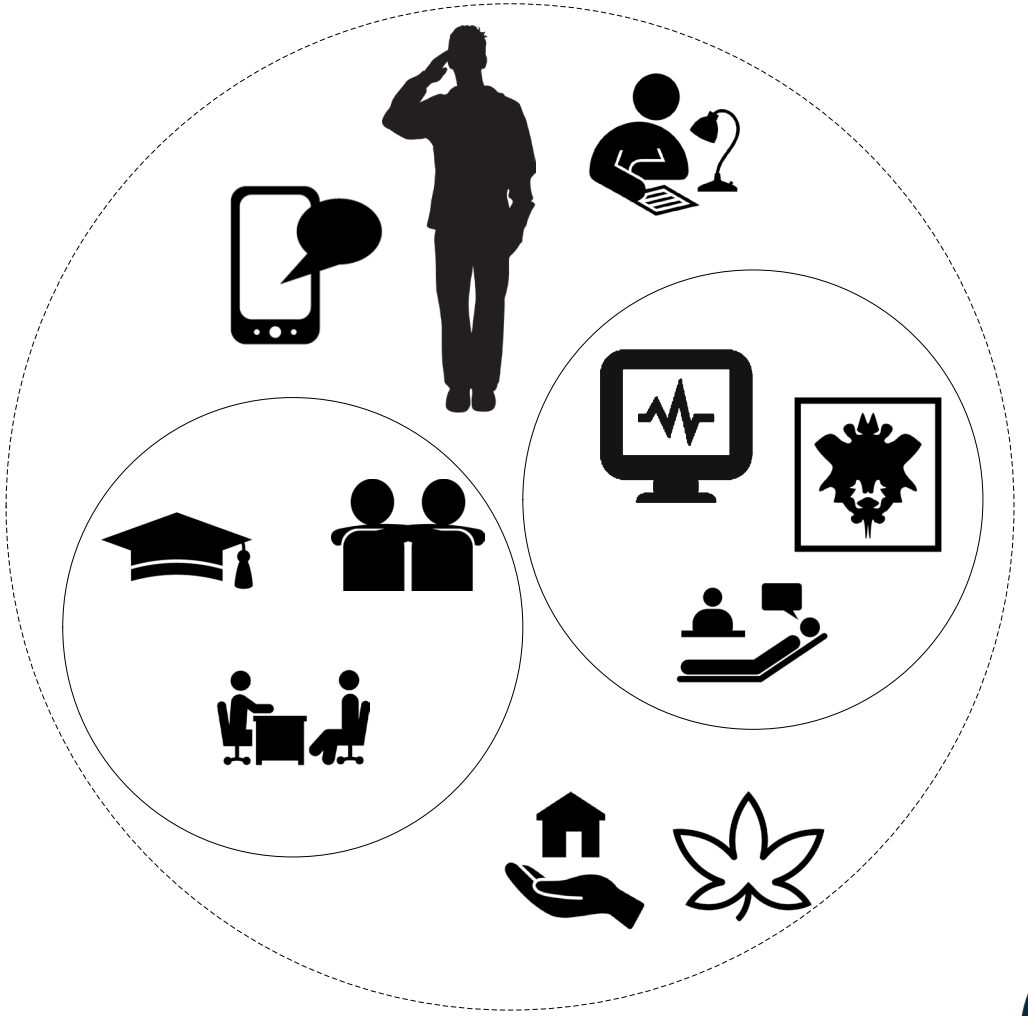
OPTIONS FOR BH PROVIDERS

- Seem big
  - Independent Practice Associations (IPA) are a way to partner with other agencies in order to offer comprehensive, integrated services



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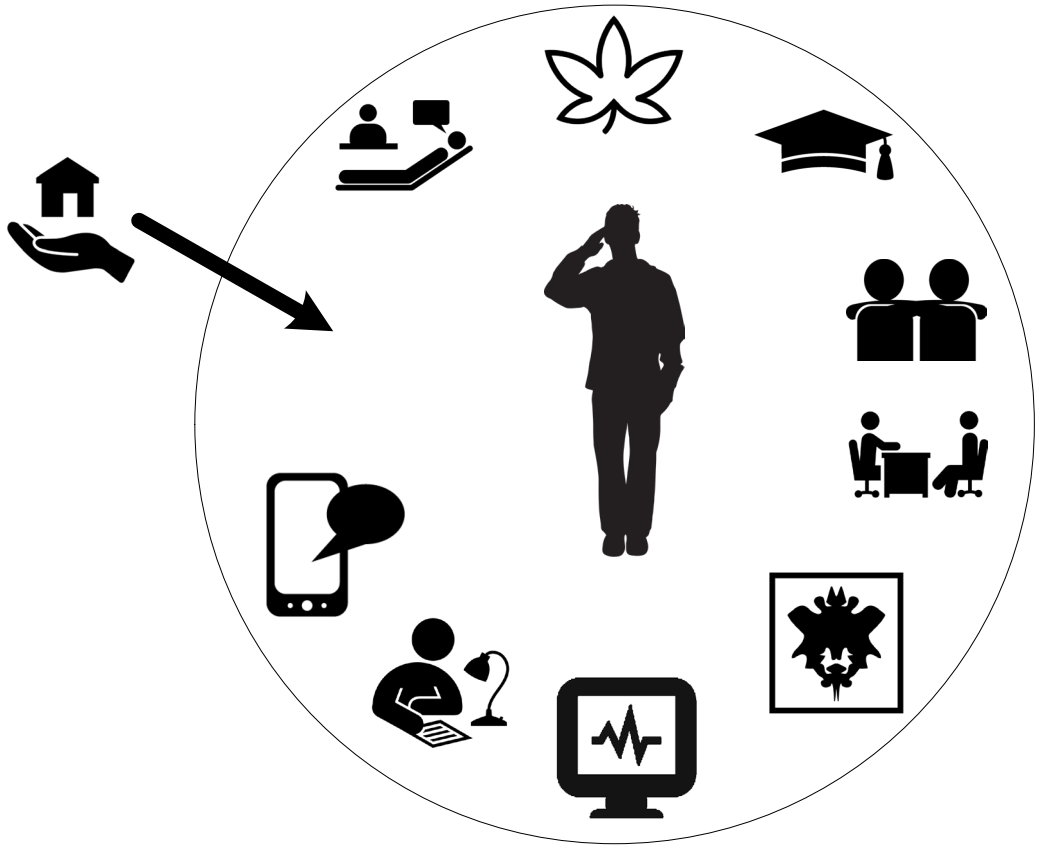
PROS AND CONS OF JOINING/FORMING AN IPA

Pros	Cons
Requires less time, expense and burden than merging	Requires significant time, expense and effort
Enables each agency to maintain its own identity, Board, fundraising base, etc.	Does not generate the same kind of economies of scale and efficiencies as a merger
Clinical integration leads to better outcomes for consumers	Governance can be challenging
Enables collective bargaining with purchasers	In order to provide comprehensive and integrated services, other providers would need to be brought in, especially primary care
If coupled with an MSO, there can be administrative efficiencies generated	IPA members are liable for the quality of care provided by other members of the IPA, which can be problematic

OPTIONS FOR BH PROVIDERS

Consolidation

- Merging into a larger entity will enable behavioral health providers to access the size, scope, services and administrative infrastructure of the larger entity



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PROS AND CONS OF JOINING A LARGER BH AGENCY

Pros	Cons
Consistency of mission	Mergers are costly, time consuming, emotionally challenging and difficult
Enhancement of the service continuum for your clients	Loss of control
Access to a much larger and mature infrastructure	Loss of organizational identity
Straightforward decision-making and governance process	May generate acrimony among your staff because of a feeling of having been ‘acquired’
Programmatic economies of scale	
Obviates any need for potential additional mergers	
Creates negotiating leverage	

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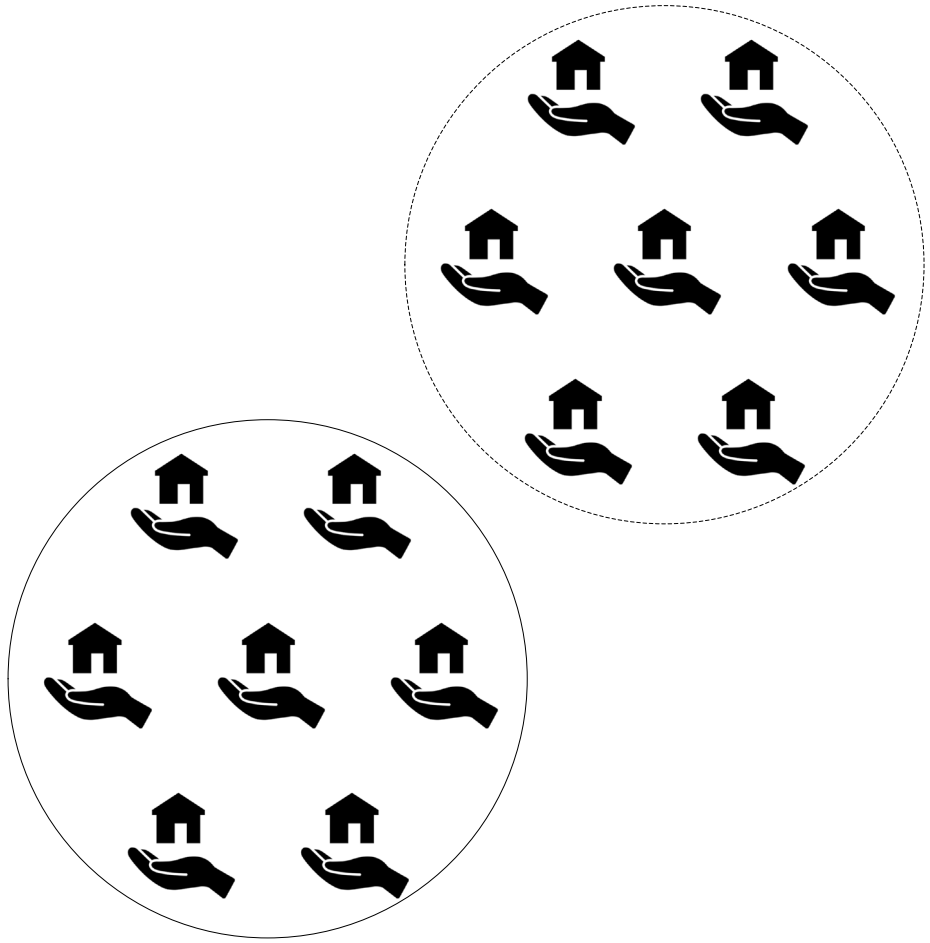
OPTIONS FOR BH PROVIDERS

- Become unavoidable
  - BH providers can establish partnerships that corner the market and increase leverage for negotiations



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PROS AND CONS OF MERGER WITH A SIMILAR AGENCY

Pros	Cons
Consistency of mission and culture	Mergers are costly, time consuming, emotionally challenging and difficult
Programmatic economies of scale	No significant enhancement to the existing continuum of care for your clients
Less likely to generate acrimony among the staff because no agency has been ‘acquired’	Because your agencies are so small, one merger may be insufficient to generate critical mass
Straightforward decision-making and governance process	
Doubles the resources available for infrastructure	

OPTIONS FOR BH PROVIDERS

- Become the BH piece of a medical organization
  - The medical system is coming to understand the importance and complexity of the people you serve, so it may make sense to join them

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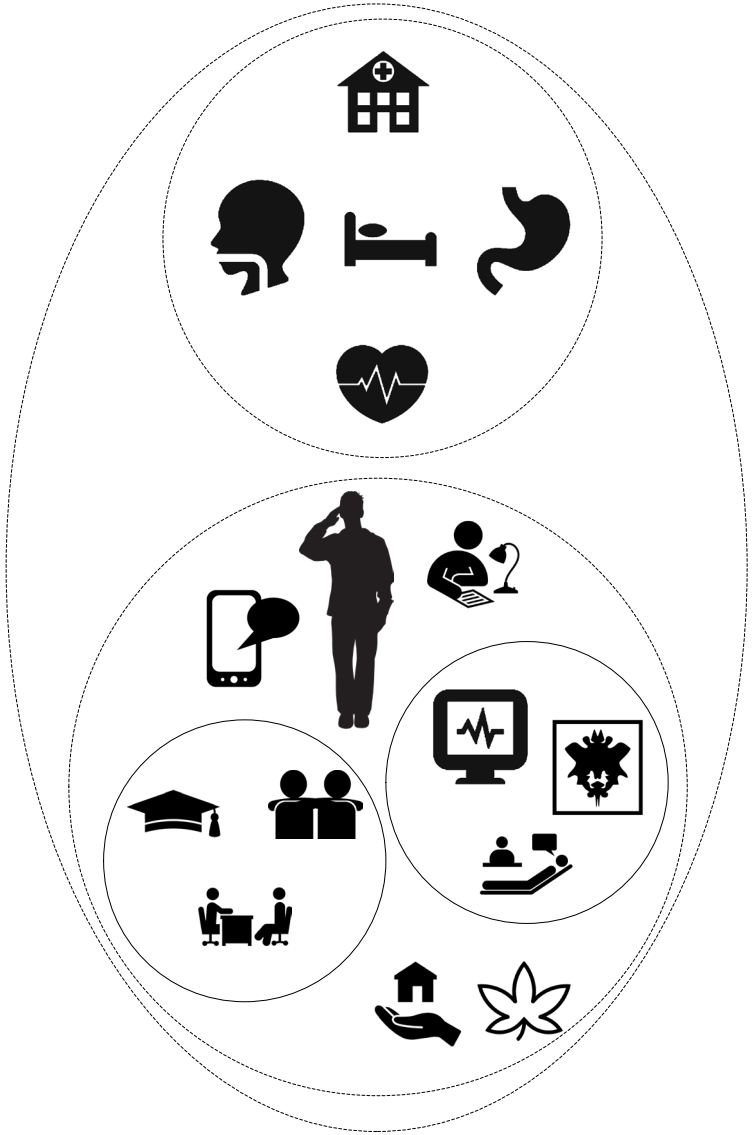
PROS AND CONS OF BECOMING THE BH COMPONENT OF A HEALTHCARE PROVIDER

Pros	Cons
Substantial enhancement of the service continuum for your clients	Mergers are costly, time consuming, emotionally challenging and difficult
Access to a much larger and mature infrastructure	Loss of control
Straightforward decision-making and governance process	Loss of organizational identity
Mitigates the need for any need for potential additional mergers	May generate acrimony among your staff because of a feeling of having been ‘acquired’
Creates negotiating leverage	Inconsistency of mission
Potential access to attribution in a VBP environment	No significant programmatic economies of scale

OPTIONS FOR BH PROVIDERS

- Combine strategies
  - Merge and then form an IPA
  - IPAs can form new IPAs with other IPAs
  - Merge to corner the market then form an IPA to expand your service portfolio



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WRAP-UP/NEXT STEPS

BRIEF EVALUATION

1. Overall rating:

1. Poor 2. Fair 3. Average 4. Good 5. Excellent

2. Content Level:

1. Too Easy 2. Just Right 3. Too Advanced

3. Which TA modalities are you interested in for additional TA? *(Select all that apply)*

1. Webinars 2. Individual Coaching 3. Group Coaching

4. Which domains are you interested in receiving additional TA in? *(Select all that apply)*

1. Financial 2. Clinical 3. Legal 4. Business

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UPCOMING SESSIONS & MORE INFORMATION

Upcoming Cohort Sessions:

- **Measurement Based Care for VBP**
  (Aug. 28, 12 – 1 pm ET)
- **Getting to an Advanced APM as a BH Provider**
  (Sept. 6, 1-2 pm ET)
- **Managing High-cost High Need Individuals**
  (Sept. 14, 1-2 pm ET)

Visit the Medicaid Business Transformation DC web page for more information and upcoming events:

www.integratedcaredc.com/medicaid-business-transformation-dc/

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HEALTH MANAGEMENT ASSOCIATES

Caitlin Thomas-Henkel, MSW
Project Director
cthomashenkel@healthmanagement.com
Link to Bio

Amanda White Kanaley, MS
Project Manager
akanaley@healthmanagement.com
Link to Bio

Samantha Di Paola, MHA, PMP
Project Coordinator
sdipaola@healthmanagement.com
Link to Bio

Meggan Schilkie
Subject Matter Expert
mschilkie@healthmanagement.com
Link to Bio