VIRTUAL LEARNING COLLABORATIVE WORKSHOP:

EVALUATING PAYMENT MODELS AND FINANCIAL MODELING

HMA

September 21, 2023
9:00-10:30 AM ET

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AGENDA

I. Orientation to the Health Care Payment Learning and Action Network (HCP- LAN) framework and trends in value-based payment models

II. Examples of arrangements across the LAN categories

III. Considerations when evaluating various types of models

IV. Approaching financial modeling of value-based arrangements

Learning Objectives

1. Describe the LAN category framework and the kind of arrangements that fall into each of the categories
2. Discuss the considerations for each of the types of arrangements when planning internally or negotiating with payers
3. Explain how to approach financial modeling of different types of arrangements and the potential data sources that could be used in modeling

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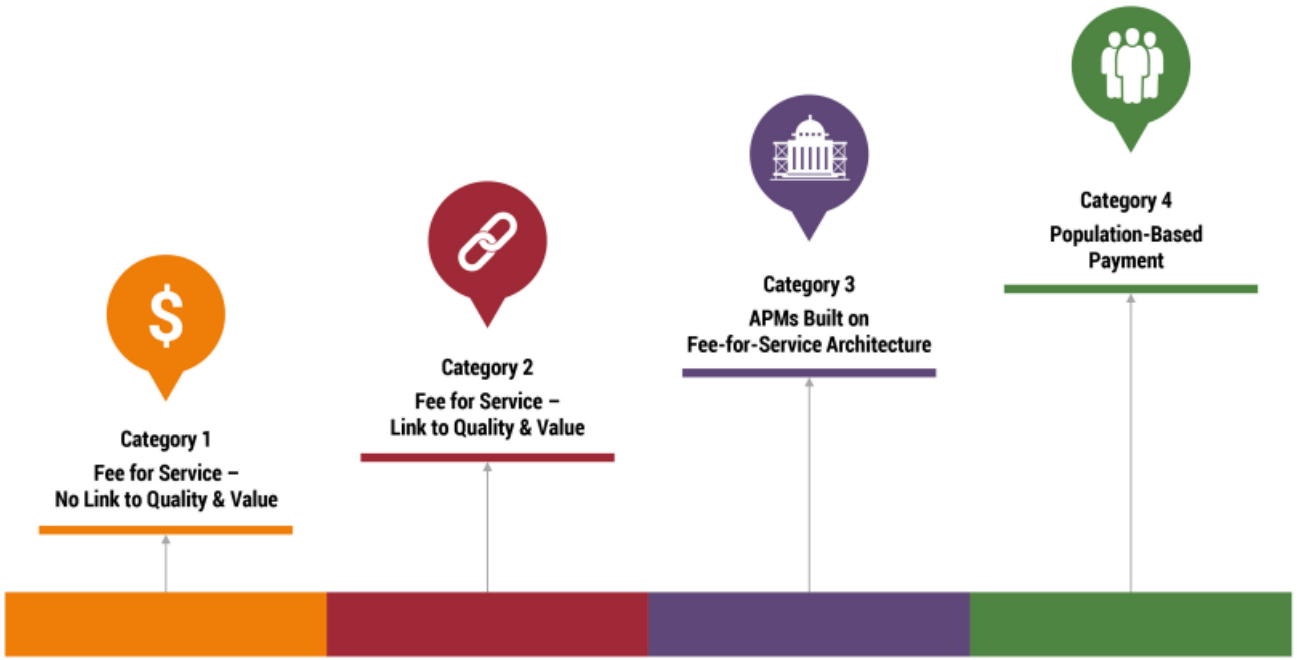
ORIENTATION TO THE HCP LAN FRAMEWORK AND TRENDS IN VALUE-BASED PAYMENT MODELS

ORIENTATION TO THE HCP LAN FRAMEWORK – CONTINUUM AND STEPPINGSTONES

CATEGORY 1	CATEGORY 2	CATEGORY 3	CATEGORY 4
FEE FOR SERVICE – NO LINK TO QUALITY & VALUE	FEE FOR SERVICE – LINK TO QUALITY & VALUE	APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE	POPULATION – BASED PAYMENT
	A Foundational Payments for Infrastructure & Operations (e.g., care coordination fees and payments for HIT investments)	**A** APMs with Shared Savings (e.g., shared savings with upside risk only)	**A** Condition-Specific Population-Based Payment (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)
	B Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting data)	**B** APMs with Shared Savings and Downside Risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)	**B** Comprehensive Population-Based Payment (e.g., global budgets or full/percent of premium payments)
	C Pay-for-Performance (e.g., bonuses for quality performance)		**C** Integrated Finance & Delivery Systems (e.g., global budgets or full/percent of premium payments in integrated systems)
		3N Risk Based Payments NOT Linked to Quality	**4N** Capitated Payments NOT Linked to Quality



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Source: Health Care Payment Learning & Action Network. *The APM Framework.* http://hcp-lan.org/workproducts/apm-framework-onepager.pdf.
Health Care Payment Learning & Action Network. *Figure 2: CMS Payment Model.* https://hcp-lan.org/workproducts/apm-figure-2-final.pdf

CMS GOALS FOR VALUE-BASED PAYMENT MODEL ADOPTION

LAN GOAL STATEMENT

Accelerate the percentage of US health care payments tied to quality and value in each market segment through adoption of two-sided risk alternative payment models.

	Medicaid	Commercial	Medicare Advantage	Traditional Medicare
2024	25%	25%	55%	50%
2025	30%	30%	65%	60%
2030	50%	50%	100%	100%

- CMS has aggressive goals of moving providers into value-based payment models.
- Due to unsustainable medical expenditure trends, among other factors, CMS and the HCP LAN set goals to move providers into further risk.
- These goals have influenced policy and model development with aims of increasing provider participation in value-based payment models, especially safety net providers and providers practicing in underserved areas.

Source: Centers for Medicare & Medicaid Services. *Health Care Payment Learning and Action Network.* https://innovation.cms.gov/innovation-models/health-care-payment-learning-and-action-network

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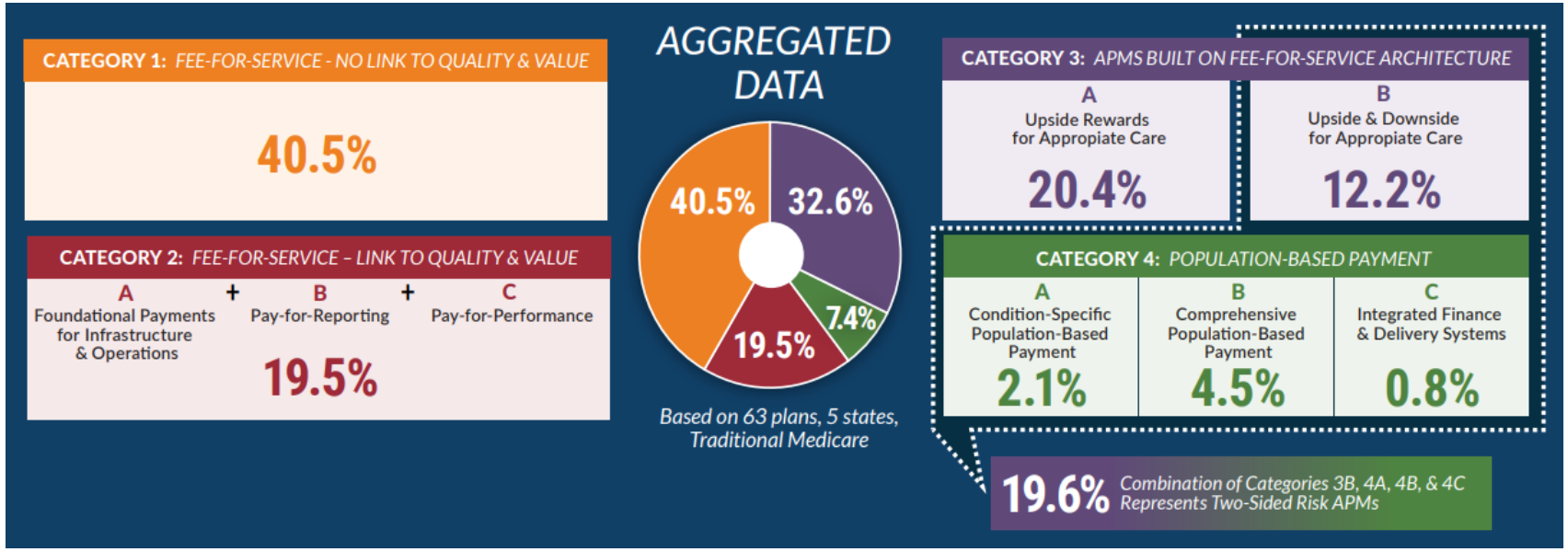
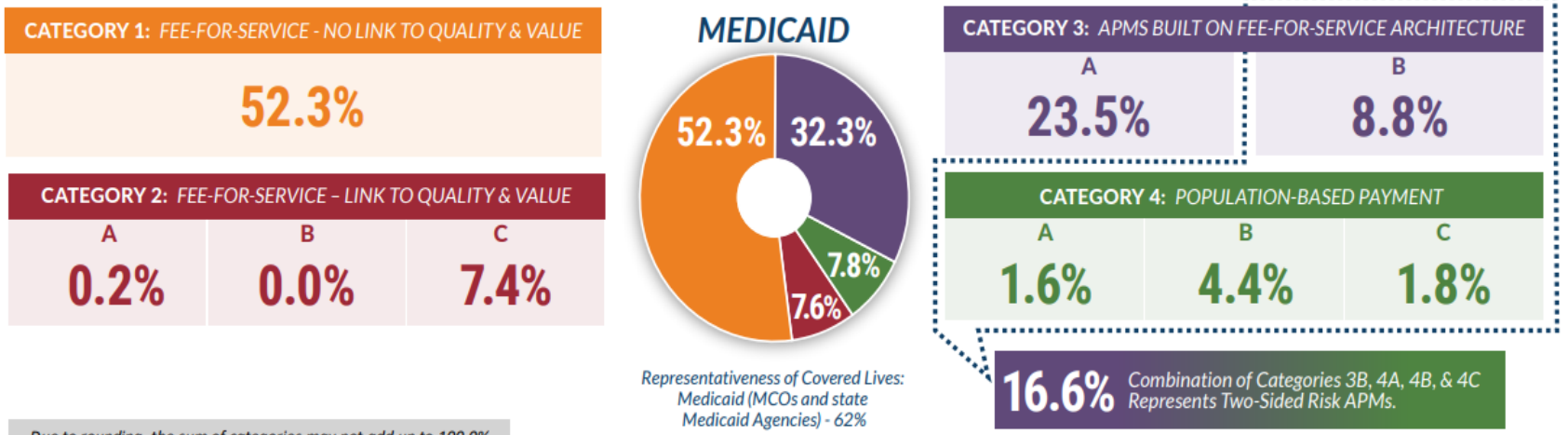
VALUE-BASED PAYMENT MODEL ADOPTION BY LAN CATEGORY





Due to rounding, the sum of categories may not add up to 100.0%.

- The HCP LAN 2021 industry survey showed:
  - More than 50% of all payments, across all payers, have pay-for-performance or more advanced valued-based arrangements with providers.
- The Medicaid line of business lags compared to overall trends.
  - Medicaid has higher level of payments tied to providers in FFS arrangements.
- However, in the past four years, the Medicaid line of business has been increasing its presence of LAN category 3 and 4 value-based models.

Source: Health Care Payment Learning & Action Network. *2022 Measurement Effort.* https://hcp-lan.org/apm-measurement-effort/2022-apm/

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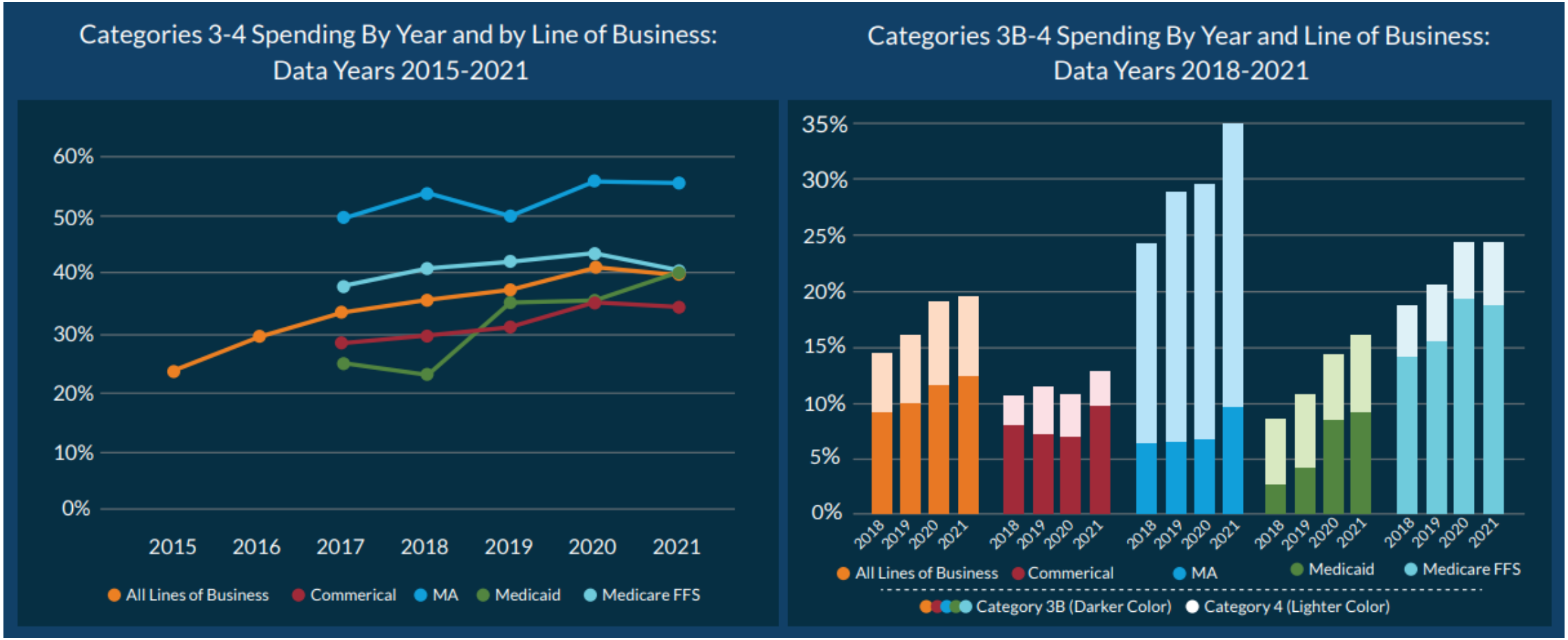
VALUE-BASED PAYMENT MODEL ADOPTION BY LINE OF BUSINESS



The Medicaid line of business has caught up with Medicare FFS in terms of spend associated with value-based arrangements centered on total cost of care, but Medicare still outpaces Medicaid in terms of spend linked to providers taking on downside risk.

Source: Health Care Payment Learning & Action Network. *2022 Measurement Effort.* https://hcp-lan.org/apm-measurement-effort/2022-apm/

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EXAMPLES OF ARRANGEMENTS ACROSS LAN CATEGORIES

2C PAY FOR PERFORMANCE EXAMPLES

DC Specific Examples

- AmeriHealth pay-for-quality programs
  - Behavioral Health Quality Enhancement Program (BH QEP)
  - Perinatal Quality Enhancement Program (PQEP)

Other Examples

- Medicare MIPS program
  - For primary and specialty care providers
- CMS' Hospital value-based purchasing program
  - Hospitals can earn bonuses based on quality metrics relevant to hospitals, such as readmission rates, sepsis care, and hospital acquired conditions

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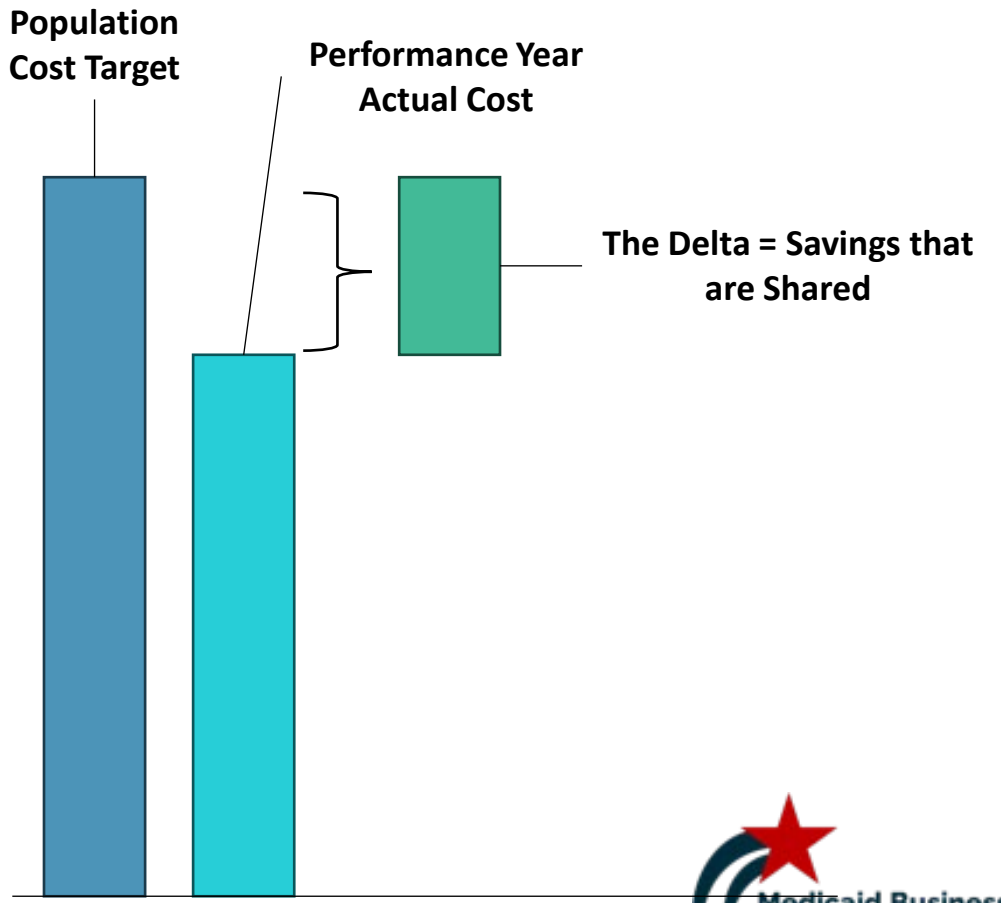
TRANSITIONING FROM PAY-FOR-PERFORMANCE TO TOTAL COST OF CARE MODELS

Pay-for Performance (2C)

Measures	How the Incentive is Earned	Provider Earnings
Metric A Metric B Metric C Metric D Metric E Metric F	▪ Close an individual gap in care ▪ Achieve a target on a metric ▪ Achieve target on a certain number of metrics ▪ Performance against target on each metric results in an overall quality score	Quality Incentive

Shared Savings on Total Cost of Care Model (3A/B)



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3A APMS WITH SHARED SAVINGS & 3B APMS WITH SHARED SAVINGS & DOWNSIDE EXAMPLES

- Medicare Shared Savings Program
  - Program that rewards ACOs when their population's total cost of care is less than the ACOs established benchmark
  - Varying levels of risk (upside only options through downside risk options)
  - Quality program integrated where ACO's performance impact shared savings earning potential
- Medicaid MCO shared savings arrangements
  - Total cost of care-based model where provider has an attributed population with a cost target to achieve
  - Cost target can be derived through historical experience trended forward or through a medical loss ratio method (i.e., % of plan revenue)
  - May have a quality program integrated that could act as a gate or adjustor to shared savings earnings
  - May have upfront funding components in the form of care coordination fees

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CONSIDERATIONS WHEN EVALUATING MODELS

CONSIDERATIONS FOR 2C / PAY-FOR-PERFORMANCE ARRANGEMENTS

- How many metrics?
- Which metrics?
  - Do the metrics align with your other payer partners' quality programs?
  - Do the metrics align with your internal quality improvement efforts?
- What attribution method will be used?
- How will incentives be earned?
- What level of efforts and resources will it take to achieve targets to earn incentives?
  - Does the incentive potential cover any costs needed to achieve the metric targets?
- Do you have internal data showing where you are performing compared to the targets, or is the payer willing to share that data with you?
- Will supplemental data be used in calculating the quality metric performance?
  - e.g., EMR data, chart reviews

CONSIDERATIONS FOR 3A&B / TOTAL COST OF CARE SHARED SAVINGS ARRANGEMENTS

- What attribution method will be used?
- How will the cost target be set or what methods will be used to develop the target?
  - Does the methodology only consider the cost of care of the population, or is the cost target developed using other factors such as a percentage of plan revenue (also known as a medical loss ratio model)?
  - What base years will be used in the methodology for target development?
  - What will be the split or share of the savings that goes to you vs. the payer?
- Will there be a quality program integrated where performance on quality impacts shared savings / earning potential?
- For downside arrangements:
  - Is the organization in a place financially, with appropriate reserves, to take downside risk?
  - How much additional upside can you negotiate/obtain for taking on a level of downside risk?
  - What downside risk mitigation options do you have (high-cost claimant thresholds, stop loss program, risk corridors, losses/earnings caps or corridors)?

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APPROACHING FINANCIAL MODELING OF VALUE-BASED ARRANGEMENTS

PROCESS FOR MODELING PAY-FOR-PERFORMANCE MEASURES

1. Understand how you earn the incentive
   - Payment for each measure achieved?
   - Payment for each quality gap closed?
   - Payment for performance on the overall quality program?
2. Determine current and projected level of performance on each of the measures
   - EHR data or is data from the payer needed to assess?
3. Develop the interventions that will get you to your projected level of performance
4. Understand the cost of the necessary interventions
   - e.g., Operational costs, staffing resources, systems/platforms, time spent in workflow redesign, etc.
5. Compare potential incentives of your projected performance against cost to improve performance

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FINANCIAL MODELING OF TOTAL COST OF CARE SHARED SAVINGS ARRANGEMENTS

Key Elements of a Total Cost of Care Model

Attribution

Benchmarking or Target Methodology

- Years included?
- Comparing provider to who/what?
- Is the benchmark risk adjusted?

Medical Cost Experience

- What is included/excluded?
- Specific cost segments that are carved out, such as BH, Rx?

Risk Mitigation

- Stop-loss
- High-cost claimant thresholds
- Risk corridors

Sharing of Savings & Quality Integration

- What's the split of savings?
- Does quality performance impact earning potential?

FINANCIAL MODELING APPROACH

	Element	Figure PMPM
1	Attribution (MMs)	180000
	Unique patients	*15000*
2	Historical Medical and Rx Expenditures (PMPM)	$ 550.00
3	Prospective Trend	5%
4	Target for Performance Year (PMPM)	$ 577.50
5	Performance Year Expenditures Total	$ 560.00
6	High-cost claimmant impact	$ 5.00
7	Baseline to Performance Year Risk Ratio	1.02
8	Performance Year Risk-adjusted Expenditures Total (removing high-cost claimants)	$ 544.12
9	Actual Performance Year Trend	-1.07%
11	Savings/Loss PMPM	$ 33.38
10	Quality Score/Adjustor	75%
12	Risk sharing rate (%)	50%
13	Final Earned savings/losses (PMPM)	$ 12.52

Scenario - Medicaid total cost of care shared savings arrangement with a provider. Pharmacy costs are included. No carve outs, but there is a high-cost claimant threshold at $150,000. Quality program acts as an adjustor to the model. Provider's share rate is 50%.

Key Considerations

- While some data can come from a provider's EHR, such as performance on quality measures, most data needs to come from the payer.
- Hence, it is critical to collaborate with payers to share data in the development of total cost of care models, so that providers can better understand their ability to impact the population and understand the potential return on moving into this type of model.
- Critical data elements required
  - Attribution
  - Claims

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WRAP-UP/NEXT STEPS

BRIEF EVALUATION

- Please Complete the Online Evaluation:

https://healthmanagement.qualtrics.com/jfe/form/SV_9zEbuA1AyGmE6IC

AFTERNOON SESSIONS

Session	Legal Track	Session	Financial Track
9 – 11 A.M. ET	Forming Community Partnerships to Participate in VBP Arrangements - Part 1	9 – 10:30 A.M. ET	Revenue Cycle Operational Excellence: A Foundation for Value-Based Payments
		9 – 10:30 A.M. ET	Evaluating Payment Models and Financial Modeling
1 – 3 P.M. ET	Forming Community Partnerships to Participate in VBP Arrangements - Part 2	1 – 3 P.M. ET	Clinical Documentation and CDPS+Rx Coding Guidelines for Value-Based Payment Optimization

Join us again from 1-3 pm ET!

https://www.integratedcaredc.com/event/value-based-payment-virtual-learning-collaborative/

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ADDITIONAL INFORMATION

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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