UNDERSTANDING COST OF CARE TO DRIVE VALUE-BASED PAYMENT ARRANGEMENTS

COST OF CARE PART 3

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INTEGRATED CARE DC
A learning community for District of Columbia Medicaid providers

PRESENTED BY:
Art Jones, MD
Chuck Weis, MBA, CPA

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Integrated Care DC is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH). This project is supported by the U.S. Department of Health and Human Services (HHS). A total of $4,598,756, or 74 percent, of the project is financed with federal funds, and 1,639,167, or 26 percent, is funded by non-federal sources. The contents are those of the author(s) and do not necessarily represent the official views of, or an endorsement by, HHS or the U.S. Government.

DHCF Department of Health Care Finance

HMA

WHAT IS INTEGRATED CARE DC?

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- Integrated Care DC enhances Medicaid providers' capacity to deliver whole-person care for the physical, behavioral health, substance use disorder, and social needs of beneficiaries.
- The technical assistance program is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH).

To improve care and outcomes, the program focuses on three practice transformation core competencies:

1. Deliver **patient-centered care** across the care continuum
2. Use **population health analytics** to address complex needs
3. Engage **leadership** to support person-centered, value-based care

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WHY PARTICIPATE IN INTEGRATED CARE DC?

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- Integrated Care DC will help ensure you have the infrastructure, knowledge, and tools you need to deliver high-value care.
- Our coaching team includes primary care, psychiatric, addiction medicine, and behavioral health clinicians with deep expertise in integrated care models.
- Educational credit (CE/CME) is offered at no cost to attendees for live webinars.
- All DC Medicaid providers are eligible.

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INTEGRATED CARE DC UPDATES

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Are you receiving our Integrated Care DC Newsletters?

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Got ideas?

Take this short survey to share suggestions and requests for trainings.
www.integratedcaredc.com/survey

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PRESENTER

INTEGRATED CARE DC
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Art Jones, MD
Health Management Associates
Subject Matter Expert
ajones@healthmanagement.com

Chuck Weis, MBA, CPA
Health Management Associates
Subject Matter Expert
cweis@healthmanagement.com

Faculty	**Elizabeth Wolff, MD, MPA** **CME Reviewer**	**Muriel Kramer, LCSW, FNAP** **CE Reviewer**	**Art Jones, MD** **Presenter**	**Chuck Weis, MBA, CPA** **Presenter**
Company	No financial disclosures	No financial disclosures	No financial disclosures	No financial disclosures
Nature of relationship	N/A	N/A	N/A	N/A

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- Health Management Associates (HMA), #1780, is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved as ACE providers. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. HMA maintains responsibility for this course. ACE provider approval period: 09/22/2022–09/22/2025. Social workers completing this course receive 1.0 continuing education credits.
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- The American Academy of Family Physicians (AAFP) has reviewed Integrated Care DC Webinar Series and deemed it acceptable for AAFP credit. Term of approval is from 02/21/2024 to 02/22/2025. Physicians should claim only the credit commensurate with the extent of their participation in the activity. This session is approved for 1.0 Online Only, Live AAFP Prescribed credits.
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- Certificates of completion will be emailed within 10–12 business days of course completion.

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AGENDA

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Understanding Cost of Care to Drive Value-Based Payment Arrangements (VBAs)

- Welcome and Program Announcements
- Value-Based Payment Nomenclature
- Sample Scenario
- Projecting financial sustainability of a modified model of care
- Proposing an alternative payment model to payers
- Infrastructure Costs Needed to Support VBA
- Coaching opportunities under Integrated Care DC
- Closing Remarks/Q&A

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LEARNING OBJECTIVES

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- Recognize the categories of value-based payment types according to the Health Care Payment Learning Action Network.
- Describe why healthcare providers need to comprehend the cost of services they offer and how it relates to reimbursement rates.
- Identify the basics of anticipating the impact of care models on patient outcomes and incentive payments in the context of value-based care arrangements.
- Express the importance of using cost information to make informed decisions about modifying existing care models and introducing new approaches to patient care.
- Explain the importance of understanding of cost of care in negotiating contracts with payers and making informed decisions about entering value-based payment arrangements.

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VALUE-BASED CARE FOR DC BEHAVIORAL HEALTH PROVIDERS

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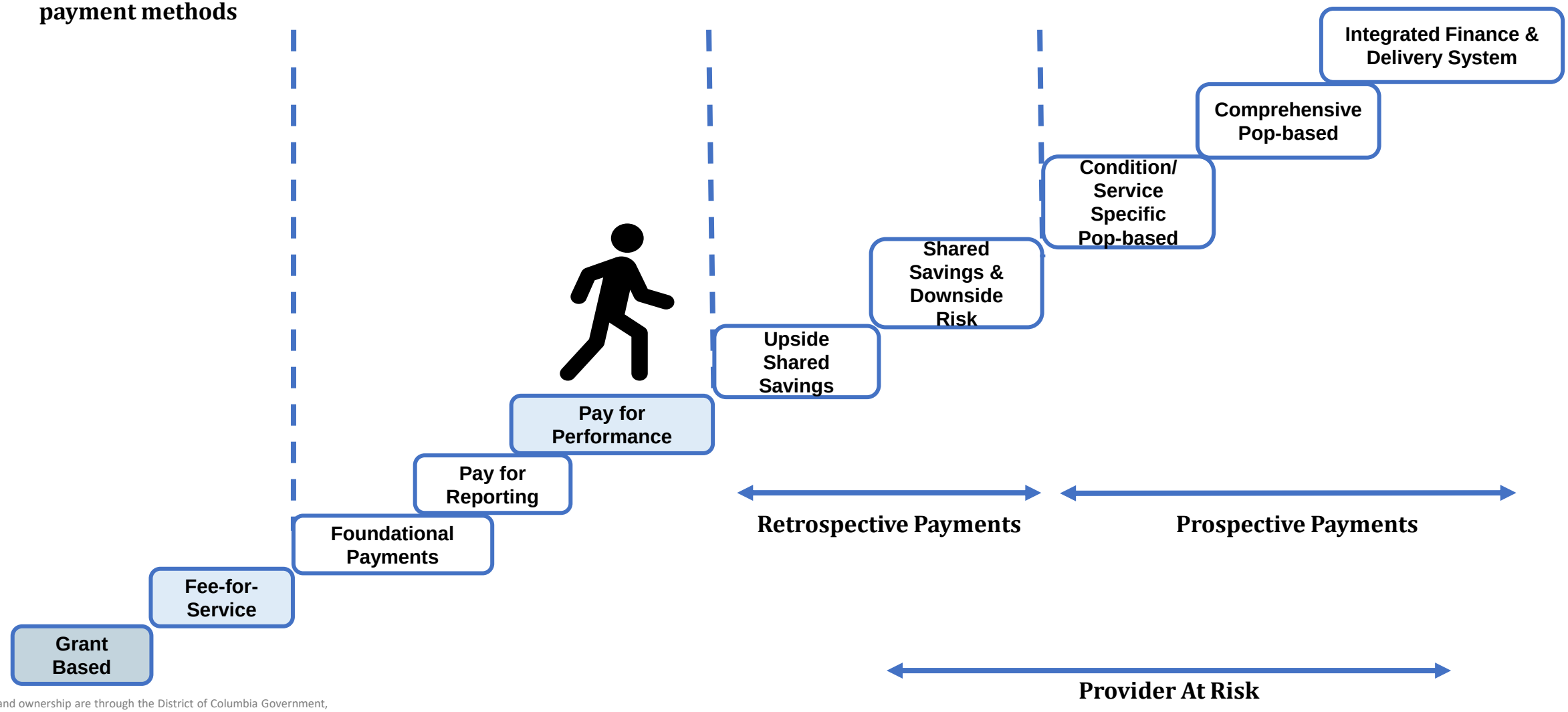

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MODIFIED AND NEW APPROACHES TO IMPROVE PATIENT OUTCOMES

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- Value-based payments reward improvements in (or in the case of superior outcomes already, maintenance of) attributed member outcomes.
- This often requires a modification to a provider's existing clinical and care management approach.
- Sometimes it requires a new model of care.
- Sometimes it requires collaboration with external provider partners.
- Often it requires additional financial resources to implement.

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SAMPLE SCENARIO

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- You are a non-profit with a mission of serving individuals with a severe mental illness, including those with co-occurring substance use.
- Most of your adult patients have physical health co-morbidities. Some see a primary care provider, but many do not.
- Of your patient payer mix, 500 are assigned to one of the Medicaid managed care health plans which pay you fee-for-service for behavioral health (BH) visits. You also receive grant funding directly from the District to pay for your enabling services specific to this target population.
- You offer ambulatory visits for your patients after hospital discharge, but the appointment show rate is only 50%, causing you to lose revenue for those slots. You send visit reminders by text but contact information is often inaccurate. You have never seen many of the individuals referred to you by the hospital discharge planner before as patients.
- Only 50% of patients fill the prescription they are given at hospital discharge.
- The 30-day rehospitalization rate for your attributed Medicaid managed care members is 22.5% but is only 15% for those who have an BH visit within seven days vs. 30% if that 7-day follow-up is missed. The average cost to the health plan for a readmission is $5,000.

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REVISED MODEL OF CARE

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- Your care team discusses the problem and develop a revised approach to transitions of care post hospitalization.
- You would like to hire a non-licensed behavioral health clinician to go to visit your patients during hospitalization to begin to establish a trusting relationship and verify patient contact information. Once the model of care has demonstrated success with your attributed members, you would like to implement it for Medicaid managed care patients who do not attribute to any ambulatory behavioral health provider. This clinician will try to meet the patient at time of discharge and will accompany them to a same-day appointment with a billable clinician in your clinic.
- You convince the Medicaid managed care plans to provide a lump sum care coordination fee for the first six months while you implement the program, but they want to transition to a value-based payment approach after that in which they will provide an add-on to the usual ambulatory visit amount for a follow-up within seven days of discharge. If the patient is also seen by a primary care provider within 30 days of discharge, you can earn an additional incentive payment.
- You meet with your Chief Executive Officer and Chief Financial Officer get approval of the plan and to help you calculate how much the add-on payment should be.

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PROJECTING INCREMENTAL REVENUE

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Payer Class	Financial Model

1 Managed care members	1
	• Increase billable visits
	  ○ Reduce in-person no-show rates
	  ○ Improve “billable” provider efficiency
	  ○ Increase market share
	• Value-based payments
	• Increase the encounter payment rate

2 Insured, non-managed care patients	2
	• Billable visits
	  ○ Reduce in-person no-show rates
	  ○ Increase market share
	  ○ Improve “billable” provider efficiency

3 Medically uninsured 	3 • Reduce in uncompensated care costs • Reduce in-person no-show rates • Improve “billable” provider efficiency

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PROJECTING INCREMENTAL REVENUE MEMBER ATTRIBUTION =500

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Baseline Data		
Ambulatory BH Visit Within 7 days of Inpatient Psych Discharge	% of Patients	30-day Re-hospitalization Rate
	50.0%	15.0%
	50.0%	30.0%
Blended Rate		22.5%
Attributed Membership		500
Initial Hospitalization Rate Per-Member-Per-Year		20.0%
Number of Initial Hospitalizations Per Year for Attributed Membership		100
Number of 30-day Rehospitalizations Per Year for Attributed Membership		22.5
Average Cost per 30-day Rehospitalization		$6,000
Annual Cost of Rehospitalizations		$135,000

Projected Hospital Savings with the Revised Model of Care		
Ambulatory BH Visit Within 7 days of Inpatient Psych Discharge	% of Patients	30-day Re-hospitalization Rate
	75.0%	15.0%
	25.0%	30.0%
Blended Rate		18.8%
Number of 30-day Rehospitalizations Per Year for Attributed Membership		19
Annual Cost of Rehospitalizations		$112,500
Savings		$22,500
Provider 50% split of savings		$11,250
Increased Equivalent Revenue per Post-Hospital Discharge Visit		$150
Incremental Direct Revenue Resulting Reducing the No-show rate		
Number of Increased Ambulatory BH Visits		19
Average Reimbursement per Visit		$167
Increase in Direct Service Revenue		$3,131
Total Increase in Revenue		$14,381

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STAFFING THE NEW TRANSITIONS OF CARE MODEL

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- Can I cover my incremental expenses with the incremental revenue from an improved no-show rate?
- If not, can I modify the type and/or amount of FTE required to implement the model?
- Can I partner with other DC-based behavioral health providers to expand member attribution enough to reach financial sustainability?
- Can I negotiate an alternative payment model to cover the cost and some margin?
  - A LAN Category 2A infrastructure payment (grant) to cover up the first few months of implementation.
  - Transition to a LAN Category 2C payment-for-performance add-on payment of $150 for the initial post-hospital discharge ambulatory behavioral health visit tiered to increasing the amount as the success of the intervention increases over the baseline.
- Once I have demonstrated success, can I convince the health plan to expand it to individuals who are not attributed to any ambulatory behavioral health provider?

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PROJECTING INCREMENTAL REVENUE
MEMBER ATTRIBUTION 3,000

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Baseline Data		
Ambulatory BH Visit Within 7 days of Inpatient Psych Discharge	% of Patients	30-day Re-hospitalization Rate
	50.0%	15.0%
	50.0%	30.0%
Blended Rate		22.5%
Attributed Membership		3000
Initial Hospitalization Rate Per-Member-Per-Year		20.0%
Number of Initial Hospitalizations Per Year for Attributed Membership		600
Number of 30-day Rehospitalizations Per Year for Attributed Membership		135
Average Cost per 30-day Rehospitalization		$6,000
Annual Cost of Rehospitalizations		$810,000

Projected Hospital Savings with the Revised Model of Care		
Ambulatory BH Visit Within 7 days of Inpatient Psych Discharge	% of Patients	30-day Re-hospitalization Rate
	75.0%	15.0%
	25.0%	30.0%
Blended Rate		18.8%
Number of 30-day Rehospitalizations Per Year for Attributed Membership		113
Annual Cost of Rehospitalizations		$675,000
Savings		$135,000
Provider 50% split of savings		$67,500
Increased Equivalent Revenue per Post-Hospital Discharge Visit		$150
Incremental Direct Revenue Resulting Reducing the No-show rate		
Number of Increased Ambulatory BH Visits		113
Average Reimbursement per Visit		$167
Increase in Direct Service Revenue		$18,788
Total Increase in Revenue		$86,288

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INFRASTUCTURE COSTS NEEDED TO SUPPORT A VBA

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- Managed Care
  - Needed expertise and understanding of:
    - Contracting with Managed Care Organizations
    - Pay-for-Performance and establishing relevant metrics
    - Incentive measures development consistent with model of care
  - Meeting minimal required attributed members to participate
- Clinical expertise/leadership to provide direction to care teams, i.e., gaps in care
- Data management, analytics of such data, and concise communication of same to appropriate parties
- Validation of Managed Care Organization calculations
- Ongoing reporting of clinical and financial results

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OPTIONS TO ATTAIN SUFFICIENT RESOURCES TO MEET REQUIRED ADMINISTRATIVE CORE SERVICE NEEDS OF A VBA

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- Employ or contract directly with individuals or entities that can provide the expertise needed to manage multiple VBA relationships
  - Attributed member generated incremental revenues may not be sufficient to support the investment in resources
- Pursue joining an Independent Practice Association (IPA) or Management Services Organization (MSO) to manage the entire book of administrative needs of VBAs
  - Minimal required attributed members will be measured at the IPA level
  - Economies of scale can be attained as attributed membership grows
- Partner with like organization(s) to obtain necessary resources under cost sharing arrangement

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INTEGRATED CARE DC COACHING ASSISTANCE AVAILABLE NOW!

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HMA Coaches and Subject Matter Experts can help you:

- Learn to use the financial modeling tool to calculate your current per visit costs and revenue.
- Understand existing value-based payment (VBP) arrangements with Medicaid managed care health plans or understand how you might be able to qualify to participate in those programs.
- Identify opportunities to improve performance on those VBP arrangements.
- Explore modifications to your models of care to improve outcomes.
- Project the financial sustainability of those models of care.
- Develop a VBP proposal to pitch to Medicaid managed care health plans.

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FREE INTEGRATED CARE DC TA OPPORTUNITIES!

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Join the Next Leadership Through Change Learning Collaborative

- Information on the next learning collaborative will be posted to the Integrated Care DC website. Sign-up for the newsletter to receive monthly updates on upcoming events.

Sign up for Individual Practice Coaching

- www.integratedcaredc.com/signup-form
- For more information, read the FAQs: www.integratedcaredc.com/faqs

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Q&A

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REFERENCE LIST

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- Exploring Value-Based Payment for Substance Use Disorder Services in the United States. (2023). SAMHSA. https://store.samhsa.gov/sites/default/files/pep23-06-07-001.pdf
- Value-based provider enablement — the new paradigm in behavioral health; how actionable data and connecting with the right partners are improving outcomes and lowering costs. (2024). Modern Healthcare. https://s3-prod.modernhealthcare.com/2024-02/wf12362583-ohb-30.4-vbc-white-paper%20final.pdf
- Rothrock, N., et al. Understanding and Preparing for Value-Based Care: A Primer for Behavioral Health Providers.(December 13, 2023) RAND Health Care. https://www.rand.org/pubs/external_publications/EP70327.html

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WRAP UP AND NEXT STEPS

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- The webinar recording will be available within a few days at: www.integratedcaredc.com/learning
- **Upcoming Webinar:**
  - *Quality Improvement to Optimize Financial Outcomes – Cost of Care Part 4,* Tuesday, May 7, 2024, 12:30 – 1:30 pm ET
- For more information about Integrated Care DC, please visit: www.integratedcaredc.com

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