Value Based Care:
Strategic & Business Model Considerations

Ohio State University Health Services Management and Policy Institute Alumni Society Management Institute
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Discussion Points

1. Context & Perspective
2. Federal & State Drivers
3. The Importance of Integration
4. Parting Thoughts
What if:

カー industry had to be **80% electric by 2020?**

켜Utility industry had to be **80% renewable by 2020?**

The oversight and regulatory implications would outdo health care:

- Clean Air Act, EPA, NHTSA, SEC, Department of Transportation, NLRB, FERC, PUCs, State EPAs, etc. would each have a say in the transformation of those industries;
- Each would have their own rule making to implement changes needed to reach regulatory benchmarks
Value Based Care (VBC)

More than just different reimbursement & a new contract

VBC is not an amendment to a managed care contract; it’s a new business model for providers & payers

VBC is the means for moving towards population health vs FFS

With this change in business models, the regulatory implications are significant.
Federal & State Drivers

Different Paths to Transformation; no “right” way

MACRA
- Overview
- Sustainable Growth Rate
- APM vs MIPs

CPC +

Ohio CPC
The Medicare Access and CHIP Re-Authorization ACT (MACRA) of 2015 was signed into law, permanently repealing the Sustainable Growth Rate (SGR) formula and imposing a new payment methodology for Medicare Part B payments starting in 2019.

New Payment Methodology

1. Locks Medicare Part B Reimbursement Rates at Near-Zero Growth
2. Creates Payment Tracks
   • Merit Based Incentive Payment Systems (MIPS)
   • Advanced Alternative Payment Models (APMs)
Overview

- Comprehensive Primary Care Plus (CPC+)
  - National Advanced Primary Care Medical Home Model
  - Aimed to strengthen primary care through a regionally-based multi-payer reform and care delivery transformation
  - 2 Primary Care Practice Tracks

- Goal of CPC+:
  - Improve Quality of Care
  - Improve Patient’s Health
  - Spend Health Care Dollars By Key Comprehensive Primary Care Functions (i.e. Access, Care Management, Care Coordination, Patient & Caregiver Engagement, Planned Care & Population Health)

- 3 Payment Elements
  1. Care Management Fee
  2. Performance-Based Incentive Payment
  3. Payment under the Medicare Physician Fee Schedule
Path to Transformation

Comprehensive Primary Care

State Innovation Model (SIM)

- **GOAL**
  - Expand the capacity and availability of qualified medical homes
  - Define and administer Episode-based payments for acute medical events
- **OHIO’S ROLE**
  - Shift to PCMH/Episode Model
  - Require Medicaid MCO to participate
  - Add to MCO contracts

Episodes

- **BENEFITS**
  - Foundation for total cost/quality accountability
  - Pop-based accountability
  - Primary Care moves away from Fee for Service
  - Total Cost of Care puts accountability into the PCMH hands

PCMH

- **BENEFITS**
  - Episodes establish more specific accountability for cost/quality
  - Specialists & hospitals move away from FFS
  - Bundled payments establish financial controls across disciplines

EPISODE-BASED

*CareSource*
### Episodes can be classified across six distinct archetypes

<table>
<thead>
<tr>
<th><strong>A</strong> Planned procedures</th>
<th><strong>B</strong> Acute procedures</th>
<th><strong>C</strong> Acute emergent condition</th>
<th><strong>D</strong> Acute non-emergent condition</th>
<th><strong>E</strong> Acute symptomatic condition</th>
<th><strong>F</strong> Chronic condition</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Planned procedures" /></td>
<td><img src="image" alt="Acute procedures" /></td>
<td><img src="image" alt="Acute emergent condition" /></td>
<td><img src="image" alt="Acute non-emergent condition" /></td>
<td><img src="image" alt="Acute symptomatic condition" /></td>
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<td><strong>Notes</strong></td>
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<tr>
<td>May or may not be specific to a condition</td>
<td>General ED or IP</td>
<td>Unplanned, require immediate care</td>
<td>Spectrum of sites of care from office to ED</td>
<td>Symptom with broad differential management</td>
<td>Long-term disease mgmt.</td>
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<td><strong>Typical PAP</strong></td>
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<td>Provider</td>
<td>Provider or facility</td>
<td>Facility</td>
<td>Provider</td>
<td>Provider of facility</td>
<td>Provider</td>
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<td><strong>Examples</strong></td>
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<tr>
<td>CABG</td>
<td>Acute PCI</td>
<td>Acute asthma</td>
<td>URI, UTI, Otitis</td>
<td>Lower back pain</td>
<td>ADHD / ODD</td>
</tr>
<tr>
<td>Hip/knee replacement</td>
<td>Perinatal</td>
<td>GI hemorrhage</td>
<td>Acute anxiety</td>
<td>Headache</td>
<td>Depression</td>
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<td>HIV</td>
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</tbody>
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Ohio CPC
Activity Requirements

PRACTICES MUST PASS 100%

- Same-day Appointments
- 24/7 Access to Care
- Patient Experience
- Tests & Specialist Referrals
- Follow up after hospital discharge
- Team-based Care Management
- Risk Stratification
- Population Health Management
Ohio CPC
Efficiency Requirements

**MUST PASS 50%**

- Generic Dispensing Rate (All Drug Classes)
- Episodes-Related Metric
- Behavioral Health-Related Inpatient Admits per 1,000
- Ambulatory Care-Sensitive Inpatient Admits per 1,000
- Emergency Room Visits per 1,000
Ohio CPC
Clinical Quality Requirements

MUST PASS
50%

Pediatric Health
Women’s Health
Behavioral Health
Adult Health
Ohio CPC PMPM Payment Calculation

The PMPM payment for a given CPC practice is based on the number of members in each risk tier.

- Practices receive quarterly payments prospectively.
- Risk tiers are updated quarterly.
- 2017 PMPM values will be determined Q3 2016.
Timeline & Process

Ohio’s Comprehensive Primary Care (CPC) Timeline

- **CPC “Classic”**
  - Year 3
  - Year 4
  - Southwest Ohio’s federally-sponsored, multi-payer PCMH model

- **Ohio CPC Program**
  - Design
  - Year 1 (early entry)
  - Year 2 (open entry)
  - Year 3 ... 5 (open entry)

- **Medicare CPC+**
  - Medicare-sponsored
  - Payers apply by region
  - Practices apply within regions
  - Year 1 (CMS-selected)
  - Year 2 (CMS-selected)
  - Year 3 ... 5 (CMS-selected)
Where to Start? Integration

Integration, by definition, is to act as “one” and to become “whole”

It needs to be done internally & externally

What are we ultimately talking about?
Integration Success

Turning the current approach in the industry on its head

**Current State (Silos; Payer v. Provider):**
Negotiate → Negotiate some more → Implement → Quasi-integration

**Integration (Partnership; “Additive” Process):**
Shared Gov. → Shared Goals → ID Strat & Tactics → Build into Contract → Go Live
Think about it as “Product”

What if the DOT said to the auto industry:

• Over the next 5 years you need to achieve the “travel triple aim” - make transportation a high quality, affordable, and consumer friendly experience?

• Uh… okay. What would they do with that?

• They would focus on something they could develop, sell, people could use, understand, and it would make their lives better.

PRODUCT IS AN ACHIEVABLE FOCAL POINT THAT ENCAPSULATES BUSINESS ASPIRATIONS
Make it about Product

How do we get Payer and Provider on the same page to achieve Integration?

- VBC contract requirements are not enough to drive & sustain successful integration

- Altruism fades

- Tangible deliverables are required
The “Playbook”

The 7 steps to an integrated product offering:

1. Philosophical & Conceptual Integration
2. Integrated Governance
3. Analytics & Data Integration
4. Operational Integration
5. Quality Integration
6. Financial Integration
7. Business Development & Growth Integration
More on Governance

Integration Oversight Committee (IOC)

• Provider/Payer leadership team ultimately responsible for integration success
• Participants would include sponsoring executives, clinical leads, and business leads

Work Groups

• May consist of: QI/QA, Sales/Marketing, Contracting & Finance, Network Access & Dev., Ops Excellence, Analytics & Data Integration, Wellness & Community Impact
Result

1. Focal point for achieving Provider & Payer quality, operational & strategic goals

2. Integrated product offering with selected health partners

3. Framework for achieving the TRIPLE AIM
Parting Thoughts

- 80% of OH Medicaid members to be covered under value based reimbursement by 2018
- Practice Transformation v. Metrics “Checklist”
- It is good to be a FQHC and it could get better
- HIE platform for Ohio