SOUTH COUNTRY HEALTH ALLIANCE
Bringing Wellness Home

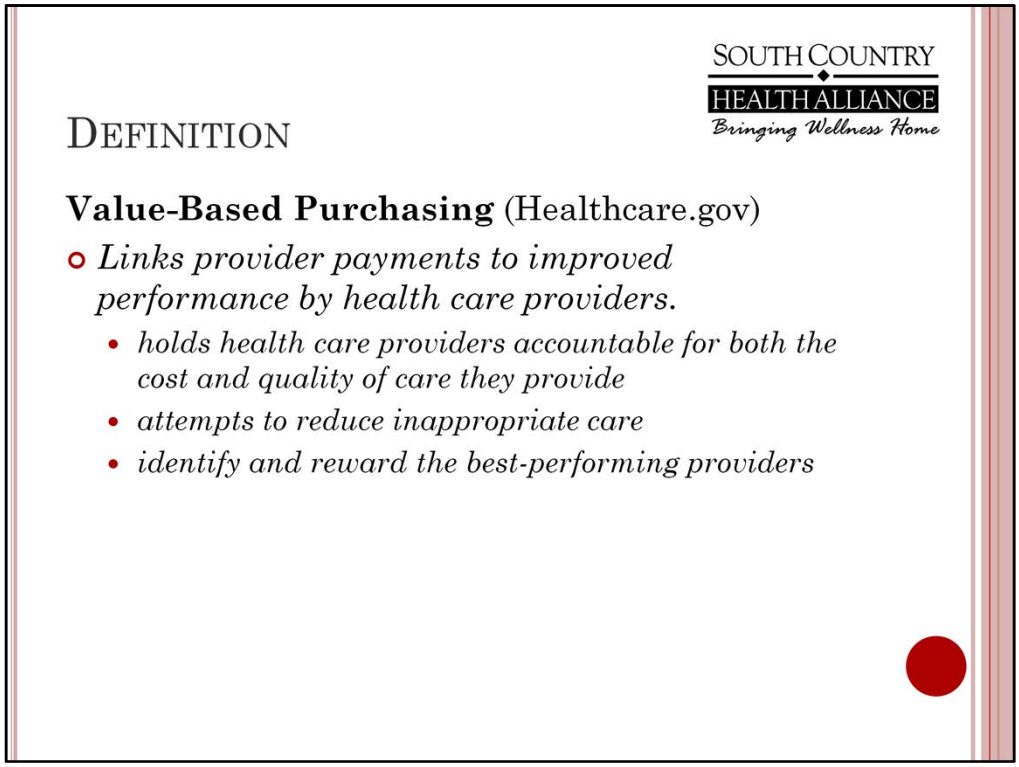
Value-Based Purchasing Programs and Minnesota Long-Term Services and Supports (MLTSS) Providers

Improve value, outcomes and innovations through partnerships

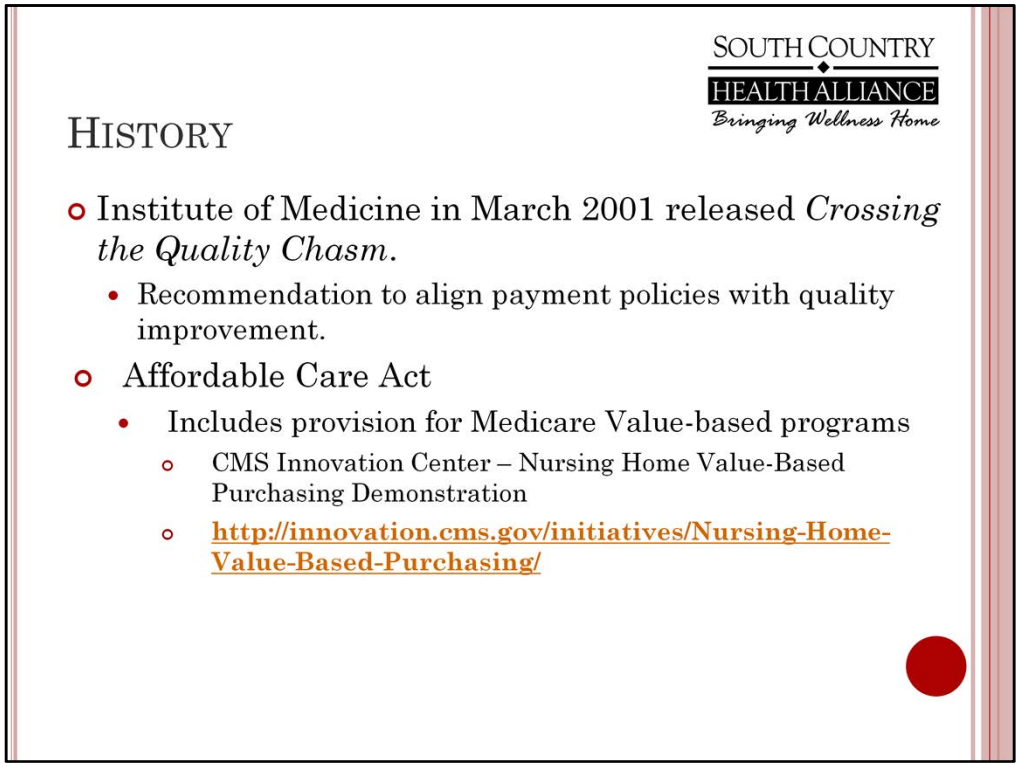
New Connections for Self-Advocacy and Innovation
Minnesota Department of Human Services - Stakeholder's Conference
August 20, 2015

Idea of Value-Based Purchasing is scary to some. During today's session I hope to give you the tools to understand basic terms, ideas, and options for working with health plans and in developing value-based contract.

History
Motivation to develop value-based pruchasing agreements
Evolution of having a value-based purchasing program
Funding
Measure development
Administrative and business processes to develop, implement, and evaluate
Challenges
Success Factors
Key Lessons



At the beginning of a presentation I like to make sure that we are all on the same page when I say “value-based purchasing” so here is the definition that I used to develop this presentation.
Many different names for value based purchasing – pay for performance, shared saving, partial risk agreements, full risk agreement, capitated systems, withholds, etc…



History – where did value-based purchasing start…

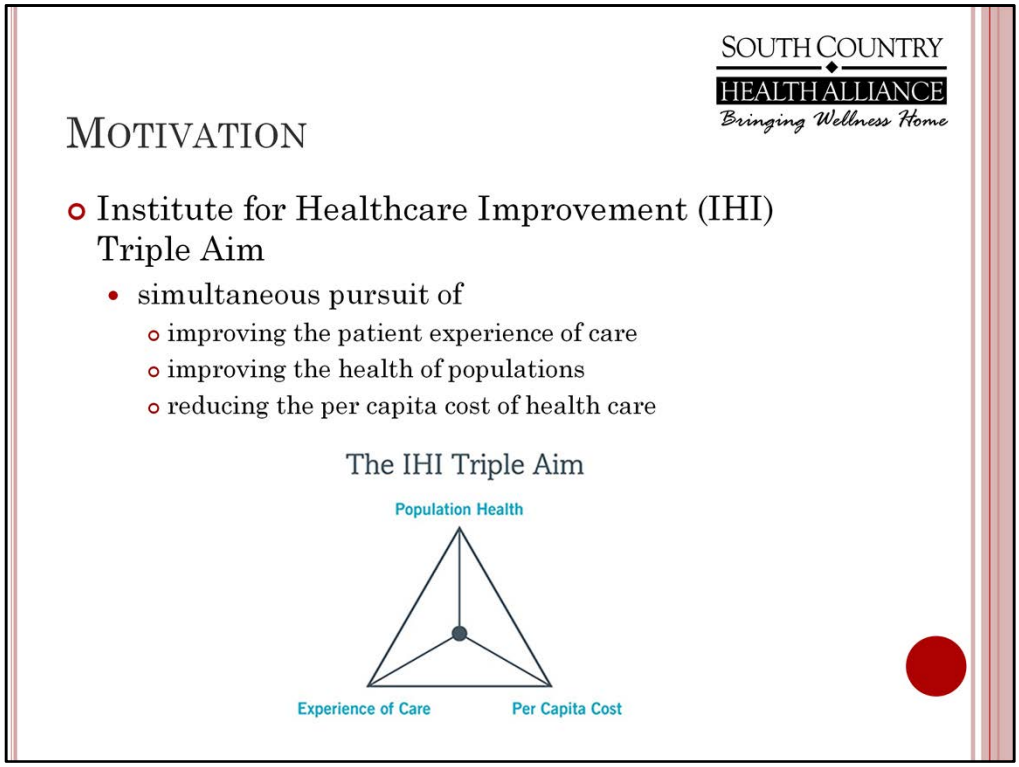
Institute of Medicine in March 2001 released *Crossing the Quality Chasm*.
Recommendation to align payment policies with quality improvement.

Value-based purchasing has started to become more popular because of the Affordable Care Act and the many provisions for innovation with government funded programs.

Includes provision for Medicare Value-based programs (i.e. Value Based Program for Hospital, Medicare Shared Savings Program, Hospital Readmit Reduction, Medical Homes)

CMS Innovation Center – Nursing Home Value-Based Purchasing Demonstration

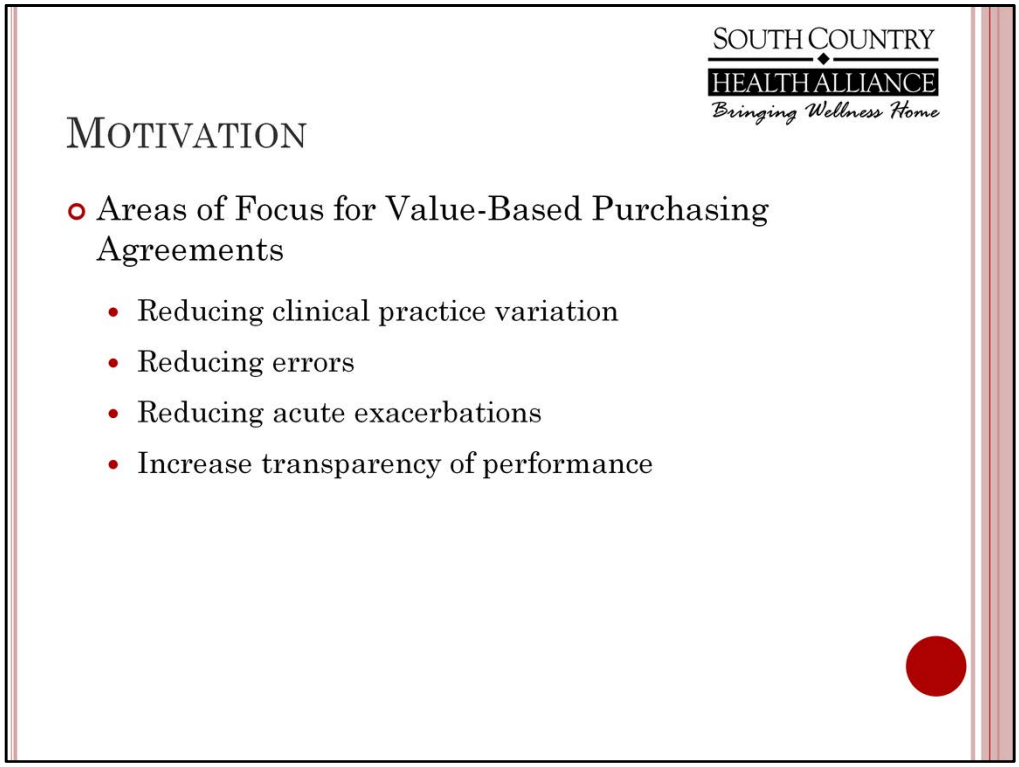
http://innovation.cms.gov/initiatives/Nursing-Home-Value-Based-Purchasing/



Why go into a value-based purchasing agreement?

- Reasons are very similar to the goals of the IHI Triple Aim
    - 1) improve patient experience of care
    - 2) improve the health of the population
    - 3) reduce costs of health care

Discussion about the per capita cost of health care in the United States and how the United States is leading developed nations. We the workers in the healthcare arena need to figure out different ways to deliver and pay for services that is sustainable. We need to be innovative.



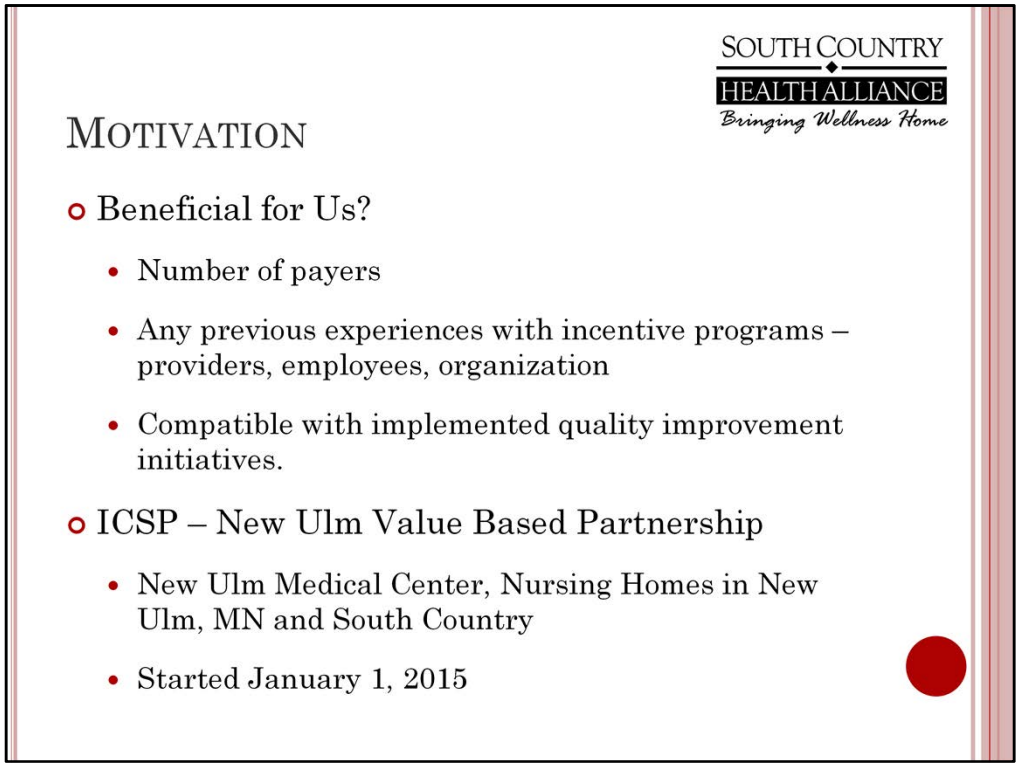
Most common focus areas for Value Based Purchasing agreements

1) Reduction of clinical practice variation – standard of care across providers, rates for preventive care will increase, implement process improvement easier

2) Reduce errors – increase patient safety and satisfaction

3) Reduce acute exacerbations – usually the most costly of the health care expenditures. Need to move towards prevention and secondary or tertiary interventions.

4) Increase transparency of performance of the providers – holds providers accountable and will increase patient satisfaction
   - discuss the CMS Star Rating program and Medicare Advantage programs. Nursing home quality reporting.



How to decide if your agency should pursue a value based purchasing agreement with a payer. Here are some pieces to consider:

1) Number of payers – health plan market share – sufficient resident/client volume to make the project effort worthwhile. If there is Low volume – payment calculations may suffer from low-end problems as sample size declines and data accuracy for determining practice performance on preventive care. Becomes problematic

- i.e. Beginning low hospitalization rate – if there is one readmission it drives the percentage up and the incentive is missed. Do not set yourself up to fail.
- SCHA Star Ratings measures – because of the low number of members who qualify for measures just a few people miss a measure and decreases the numerator and our rating can fall significantly depending upon the measure.

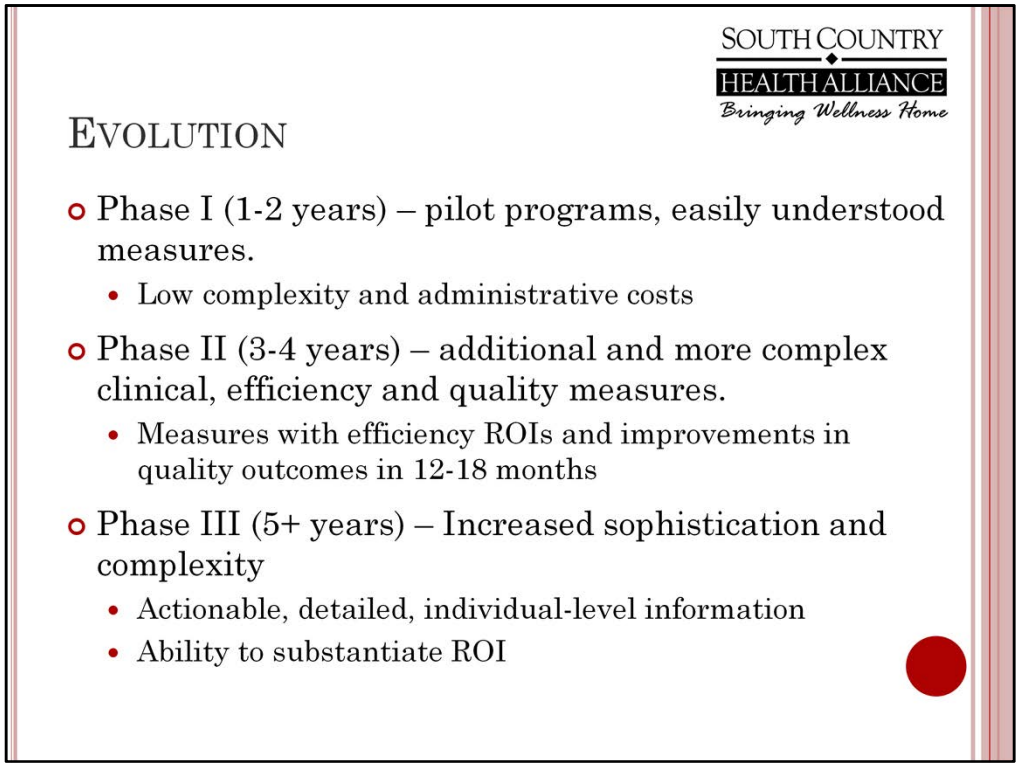
2) Positive previous experience – need provider and employee buy-in to complete the work. Are you working with any payers currently? Can you piggyback any initiatives?

3) Quality Improvement initiatives – what measures are you working for your agencies quality reporting – can you bring that measures to the table or build upon the measures. Don't work on measures that have no value to you.

Example: ICSP arrangement in New Ulm, MN with nursing homes and New Ulm Medical Center.

- Nursing homes and NUMC came to South Country with the idea to develop a partnership

to increase primary care services to residents of three nursing homes to decrease number of hospitalization and ED visits. Proposal is for South Country to pay a PMPM to the NUMC to provide primary care services on a daily basis by Nurse Practitioners as well as some pay for performance measures including review of high risk medication and increase advance care plans by the nursing homes. Just started in January 1, 2015 so no data to report.

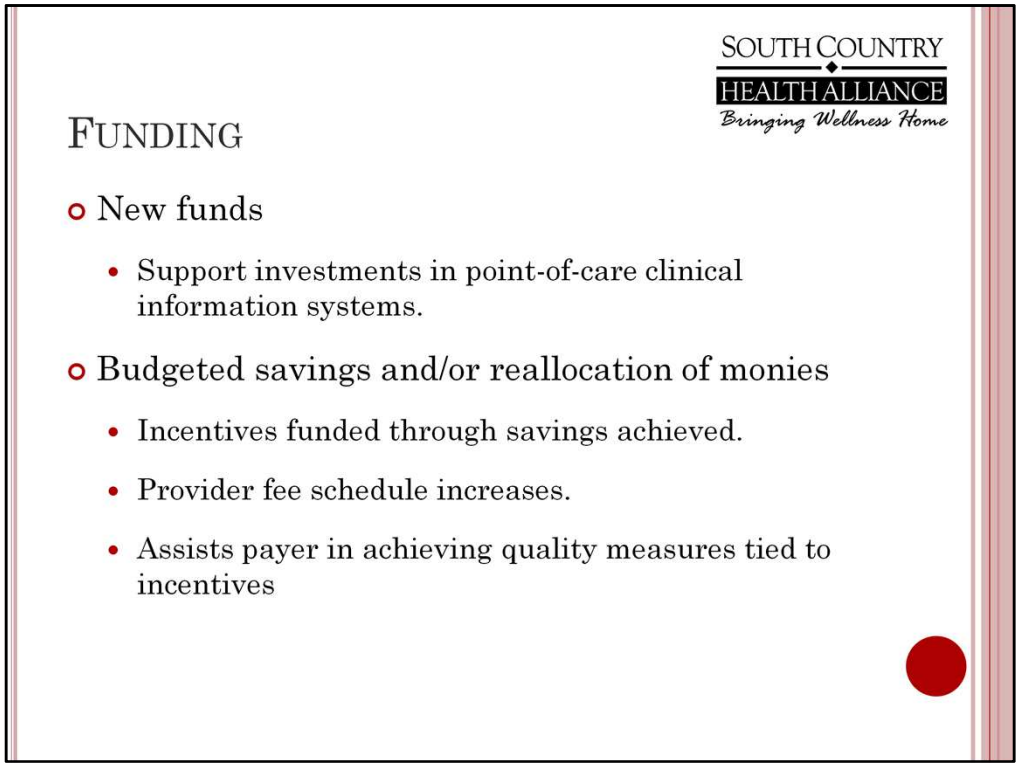


Evolution of a Value-Based Contracting. Typically moves in phases…

Phase I – Usually the first 1-2 years of a value-based contracting relationship. Introduction for the provider and payer. Pilot with low complexity (process measures) and low administrative costs. Examples would include pay for performance measures or incentive payments for assessments completed, mammograms, vaccinations, advance care plans completed.

Phase II – Years 3-4 move to measures that are a bit more complex and start looking at outcomes and efficiency ROIs. Examples would be reduced reduce hospitalizations or reduction of ED visits. Might be a shared savings model that at the end of the year you look at how much health care dollars were saved through the interventions and split the savings between the payer and provider.

Phase III – Year 5+ - More sophisticated relationships and complexity. Drill to the savings by patient/member/client, fully support the ROI of the agreement. Example would be a Partial/full risk agreement with a capitated payment



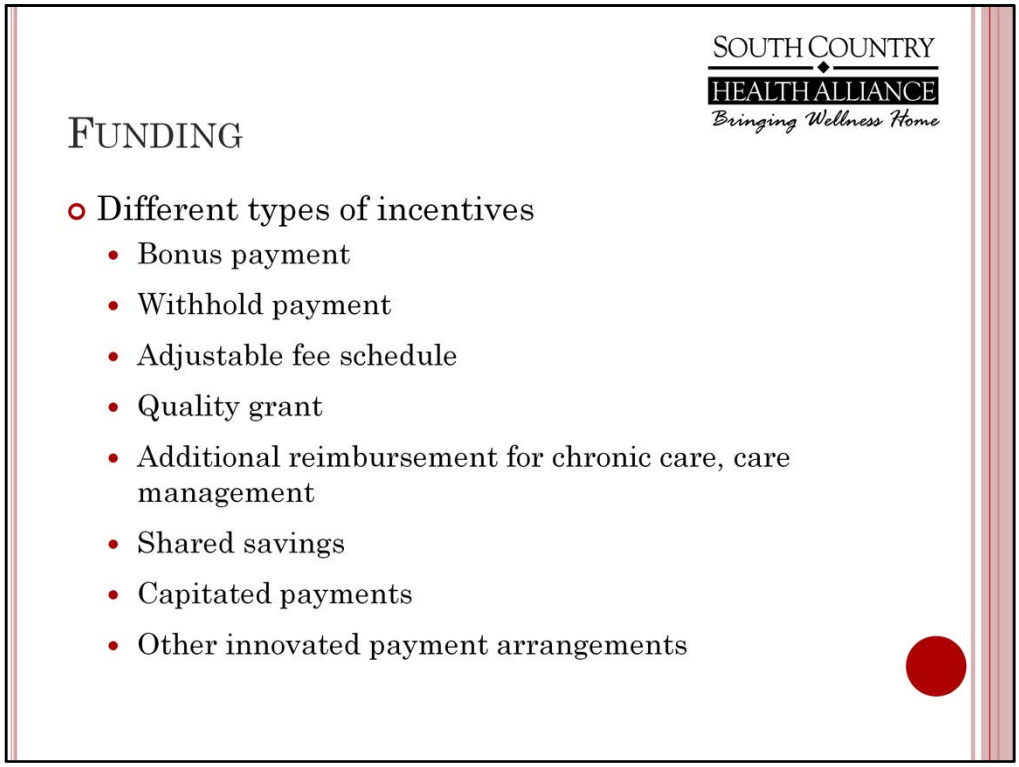
Payers/Health Plan like to be innovative but where does the funding come from for value-based contracts.

Sometimes new funds are used to start the programs – South Country worked with mental health initiative and local hospital to create the In-Reach program. New monies were used to start the program.

A majority of the value-based agreements are funded through budgeted savings and/or reallocation of monies. Health plans (especially government funded health plans) find it challenging to find funding because there are no additional capitation dollars to the health plans. The monies used needs to be reduction of cost through increased efficiency or by capturing incentive payments through quality measures by the CMS or DHS.

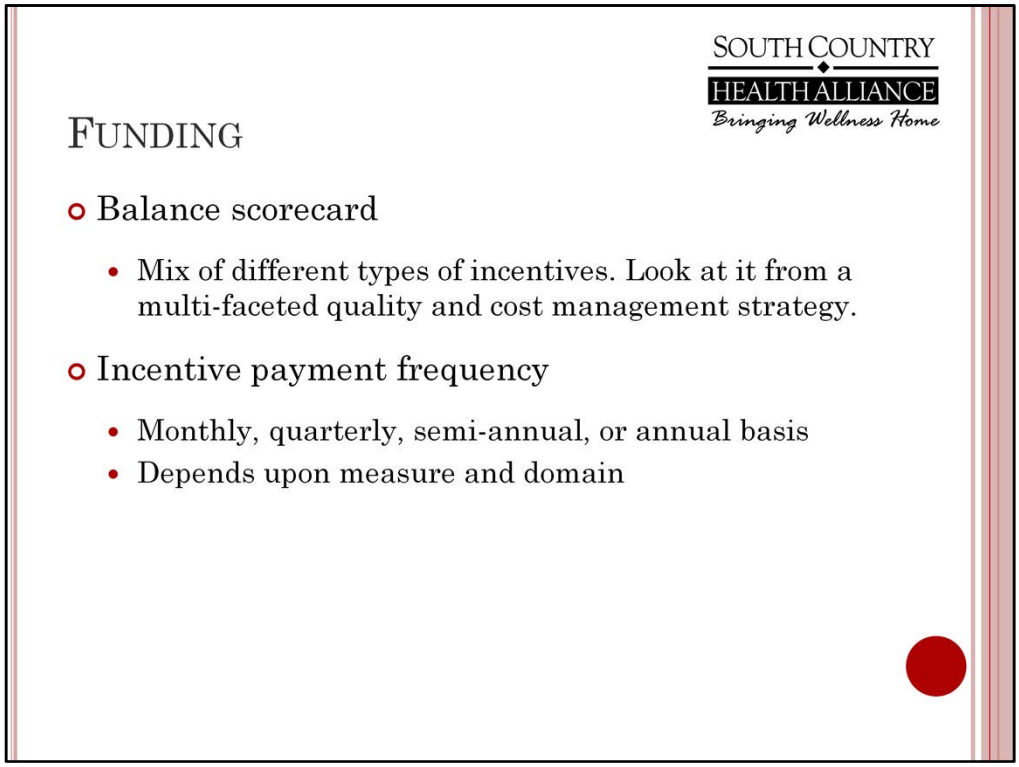
- Health plans typically do not see the benefits of investments in population health initiatives due to the churn of membership.
- Plus cannot add extra dollars without reducing their administrative overhead.

When working with a payer it is important to understand how funding is a major driver for payers/health plans to enter into a value-based agreement with the provider. Ultimately, needs to be a win-win situation for both participants – incentive funded through savings from decreased service utilization. Come with ideas – be innovative. Tell the health plans what you think is possible.



Bonus payment – annual payments from health plans. Easy to implement since contracts typically do not require renegotiations
Withhold – withhold a percentage of reimbursement and subsequently return all or portions of the withhold based on meeting minimum target requirements. Does require contract renegotiation.
Adjustable fee scheduled – tiered fee schedule and is adjusted retroactively for prior period performance on several measures.
Quality grants – monies that provide funding for specific quality improvement project to a provider. In-reach worker, case management pilot
Additional reimbursement – small payment for completing care tasks – medication reconciliation project
Shared savings – Split the savings at the end of the year between all participants – ACO model, P4P
Capitated payments – per member per month payment and typically willing to go into partial or full risk agreements.

Balance score card – common funding pool are distributed based upon weighting values and provider performance based on relative ranking or achievement of targets for specific measures.

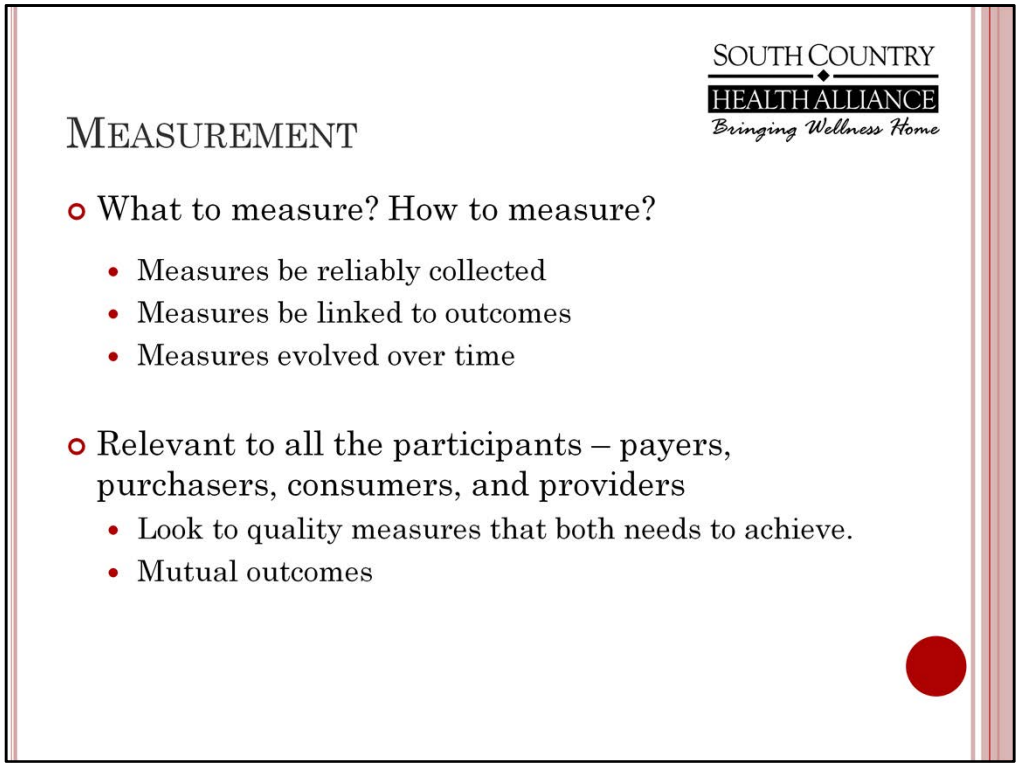


Balanced score card – balance between cost and quality measures. Several categories that are valued using different weights. Funding from a common funding pool are then distributed based on these weighting values and provider performance based on ranking or achievement of targets for specific measures

- Group environment (Good Samaritan Nursing Homes.)
- With one provider but multiple measures all with different weights so some incentive is gained and not all is lost because didn't meet the measure completely.

Incentive payment frequency – depends on measure and domain – can be quarterly, semi-annually, or annual basis.

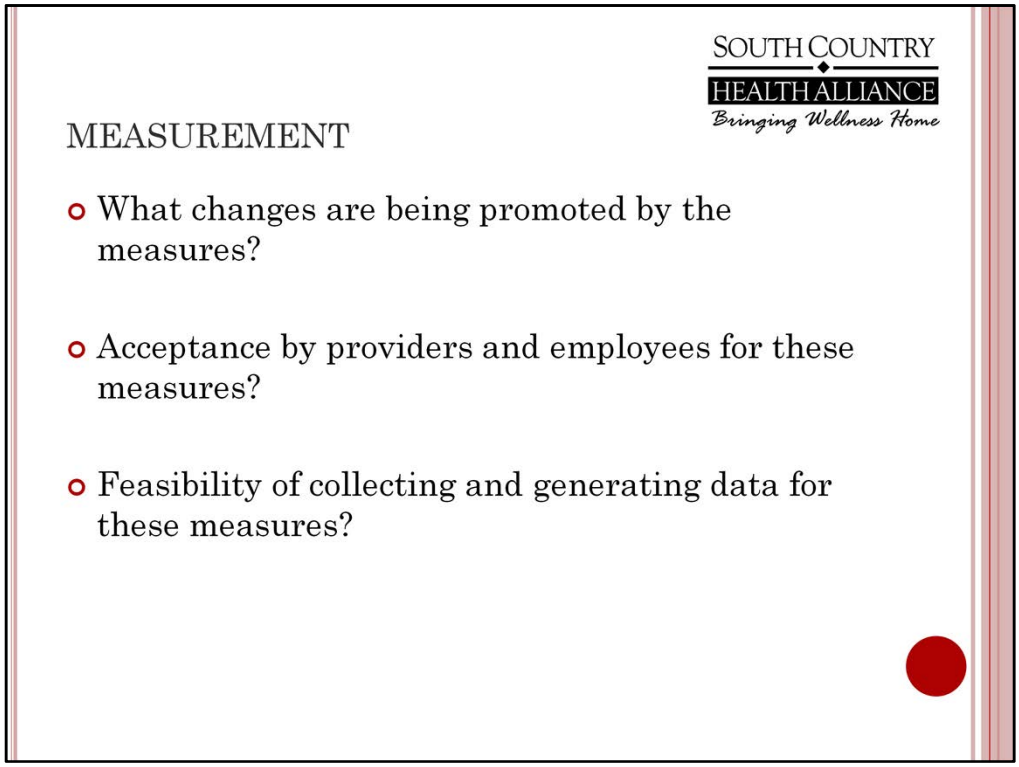
- Monthly payment reinforce provider behavioral change but are administratively burdensome
- Utilization of savings – done on an annual basis (most common) timed better with HEDIS results, satisfaction surveys, budget neutral efficiency measures, annual reconciliation of complex, tiered measure-point calculations used in the scorecard.
- Quarterly and monthly payment can be used for compliance and process measures that do not require annual reconciliation.



How to pick the measurements?

1) Reliably collected – do not want something that is administratively burdensome, manual process
2) Linked to outcomes – reduction of hospitalizations, ED visits
3) Evolve over time – cannot just do process measures year after year, pick a measure that can grow and evolve and mature to a new measure then not recreating the wheel.

I cannot stress this enough – **make sure it is relevant to all participants of the agreement**. Don't work on a measure that has no value to you but the health plan thinks it is a good idea. Hard to get buy-in, increase administrative complexity which increase cost to implement.



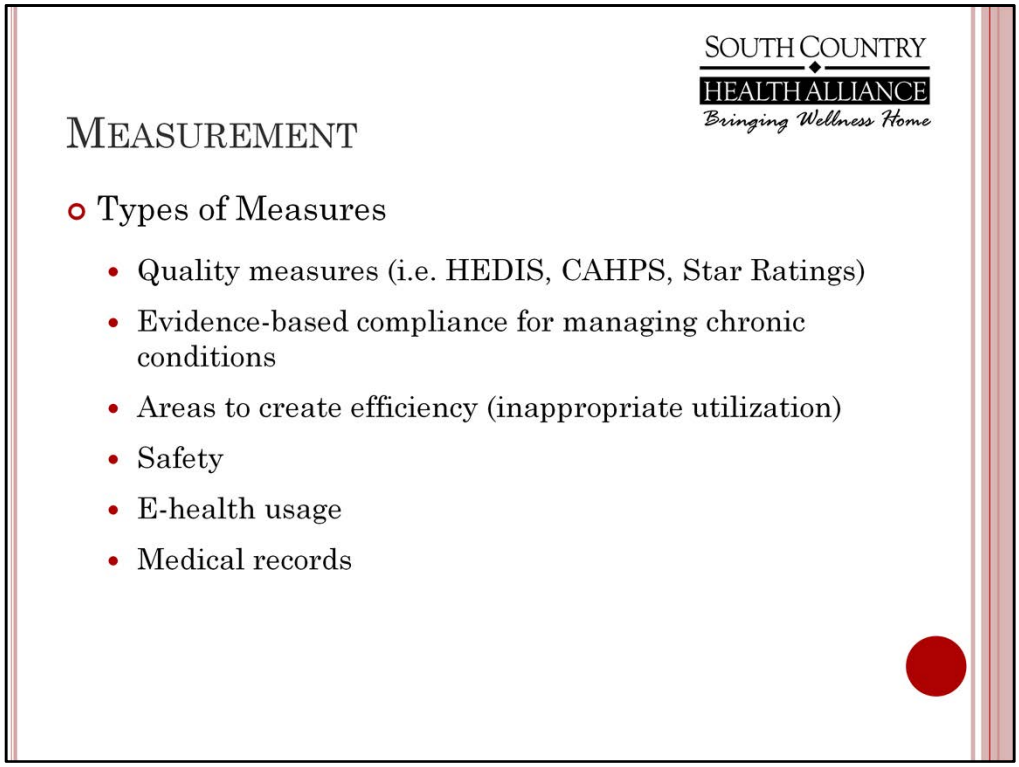
Many early stage programs start with administrative process measures since data for these can be gleaned from claims or easy manual data collection process.

Three questions to ask when developing and deciding on which measures to choose…

1) Changes – are you looking at behavioral changes (i.e. practice standards) or process changes (i.e. assessments, medication review, advance care plan)

2) Acceptance – what do you think the buy-in will be for the measure. Again, make sure it is relevant to all involved. If there isn't buy-in from the frontline workers implementing the new strategy then it will be difficult to be successful.

3) Feasibility of collecting and generating data – manual process, automatic process, easy to pull a report, need to create a form – who will control that form, etc… If you can't easily collect and pull data for the measure then it will increase frustration and willingness to continue in the future. **DATA collection is an important piece to consider. It is the one piece that will increase administrative burden and cost to a measure.** Do not want a measure that is costing you more administratively than the incentive offered by the health plan.



All groups have quality measures – health plans, hospitals, clinics, nursing homes, home health agencies, and even HCBS providers

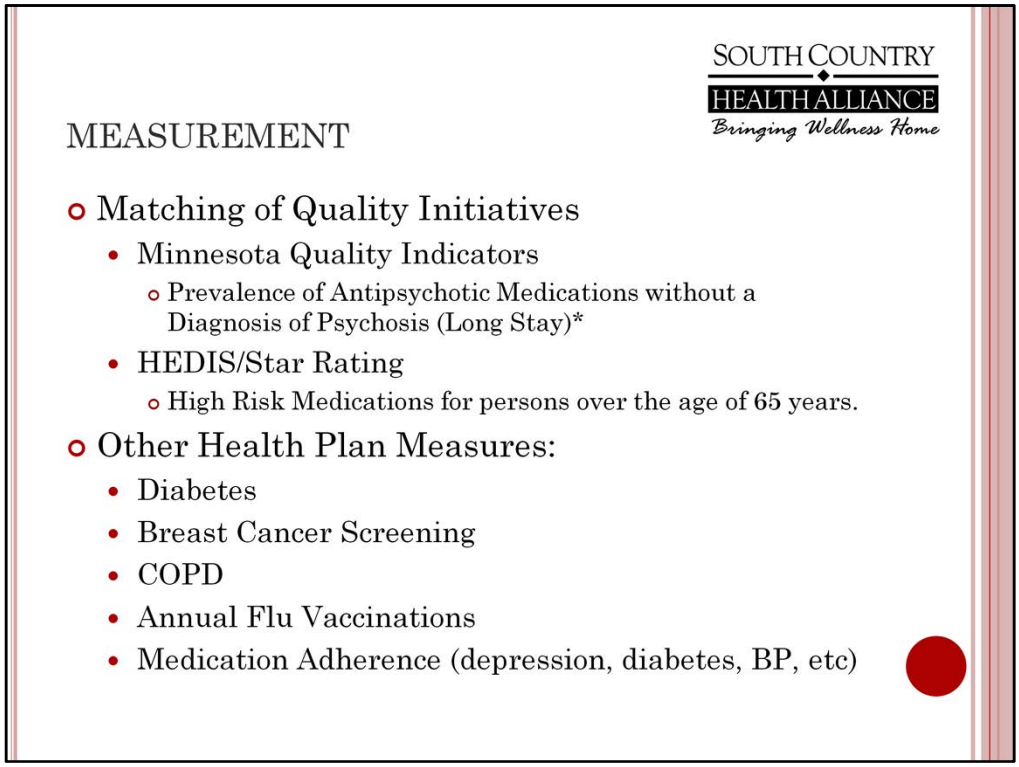
Compliance – standard practice guidelines

Efficiency – triaging strategies, preventive measures and making appointments, preventing readmissions – medication review

Safety – falls prevention, preventing readmissions

E-health usage – e-prescribing, BMI is completed, many quality measures are dependent upon what is in the EMR, need the fields completed.

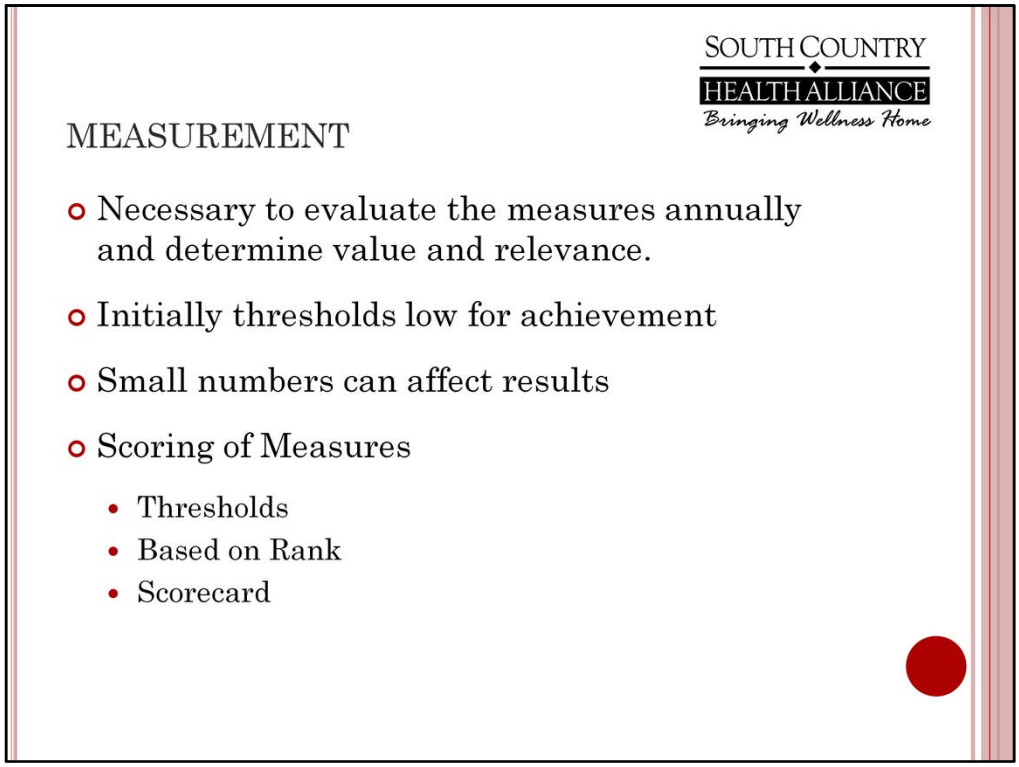
Medical records – Advance care planning is documented – many good things are being done by providers but if it is not documented – it is not done.



Work together and figure out how you can help each other meet your quality goals.

Example – nursing homes follow the Minnesota Quality Indicators and health plans have the HEDIS/Star Rating quality measures. Both quality programs include something relating to medication review. Work together and find what is meaningful to all parties.

Other examples where there is cross over include – diabetes, breast cancer screenings, COPD, vaccinations, medication adherence.



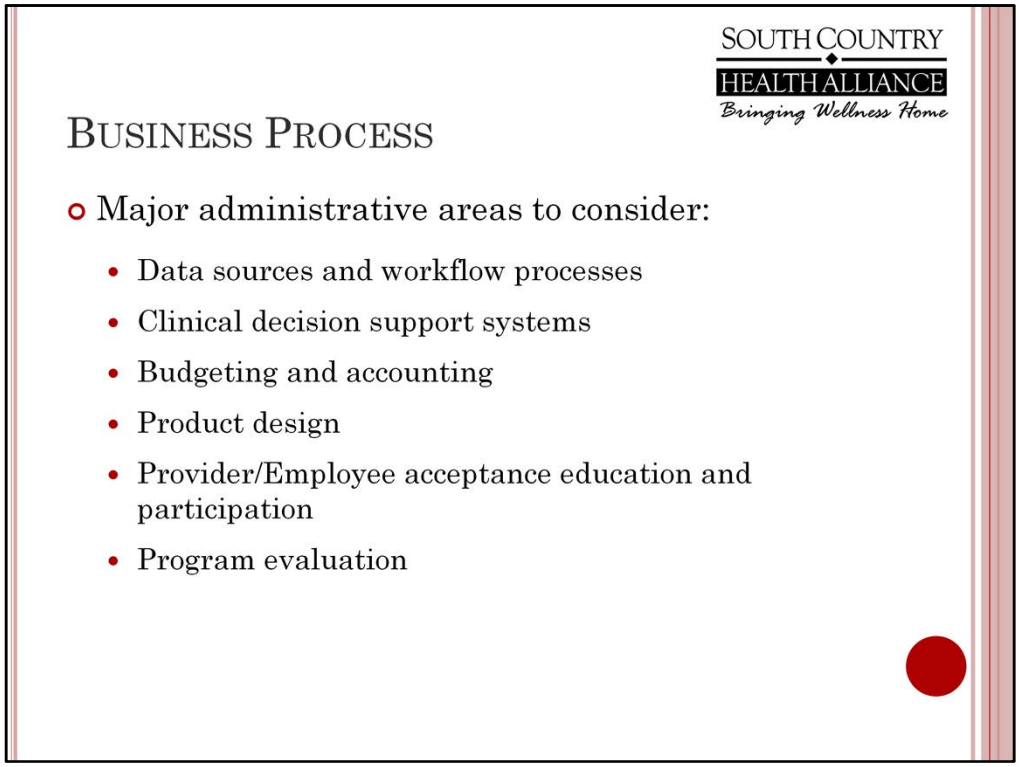
Key Points –

Annual review of measures – determine value and relevance

Thresholds – simple scoring, develop the thresholds so that the measures are achievable. It doesn't help anyone including payers or providers if the thresholds are too high or difficult to achieve. Decreases motivation to participate and increases the requests to keep doing in the "old" way.

Small numbers – Watch the small numbers and don't sabotage yourself from achieving the goals because your denominators is too small.

Different way to score the measures include:
1) Thresholds
2) Based on rank – statistical distribution – providers that perform in the top tier
3) Scorecard – group of measures – set of goals. Weighted values assigned to categories, measures have eligibility criteria for domains and measures, typically achieve of multiple domains – not just one or two measures.



Must not be overly complicated or expensive to administer – processes must be well structured and simplified as possible.

Numerous administrative challenges –

1) Data sources - many calculations are manual or commonly performed using spreadsheet software or complex statistical software. Minimal systems set up to calculate value-based agreement /contracting programs.

And workflow processes – don't make things overly complicated.

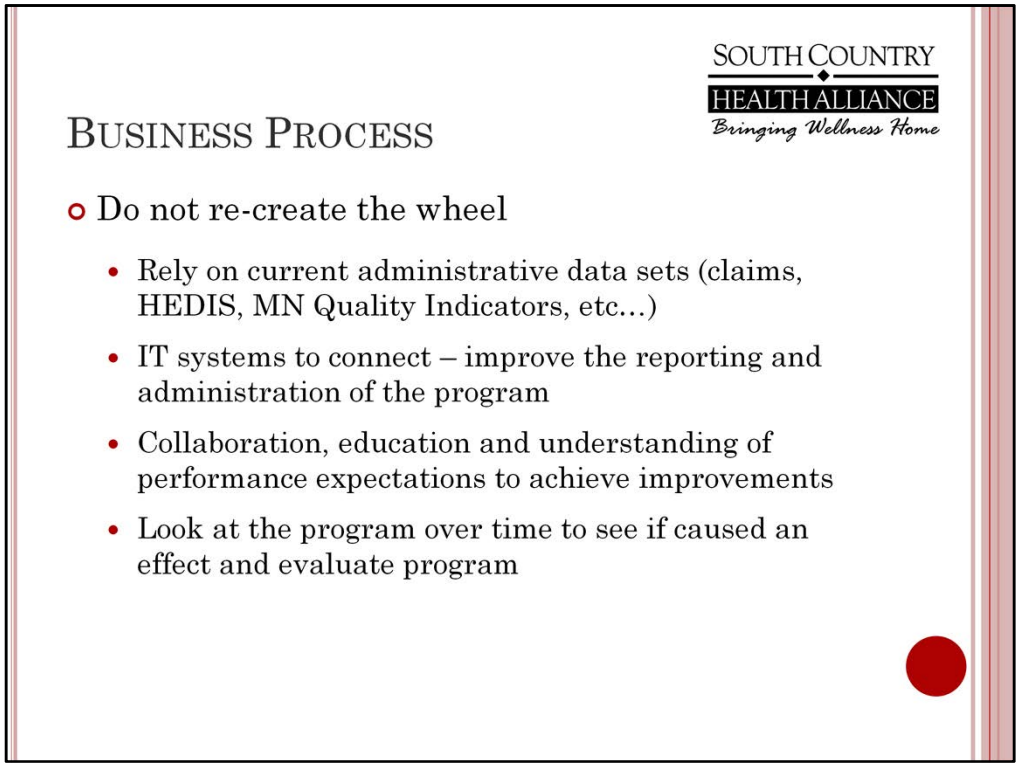
2) Clinical decision support systems – EMR are you able to incorporate the new process measures to make things easier

3) Budgeting and accounting – don't forget to include the financial people from your organization, Meaningful incentives – do not spend more money administrative implementing than the monetary value of the incentive, make sure to think about start-up costs (including staff time to set up the program).

4) Product design – keep it simple, make it relevant to all people, Use measures that do not create undue administrative burdens, Clinically relevant

5) Provider/Employee – buy-in, relevant to all participants

6) Program evaluation – data collection and evaluation not complicated, be mindful when planning interventions that you will be able to collect the data and evaluation the information, Sufficient volume – repeat myself – VERY VERY important to be successful

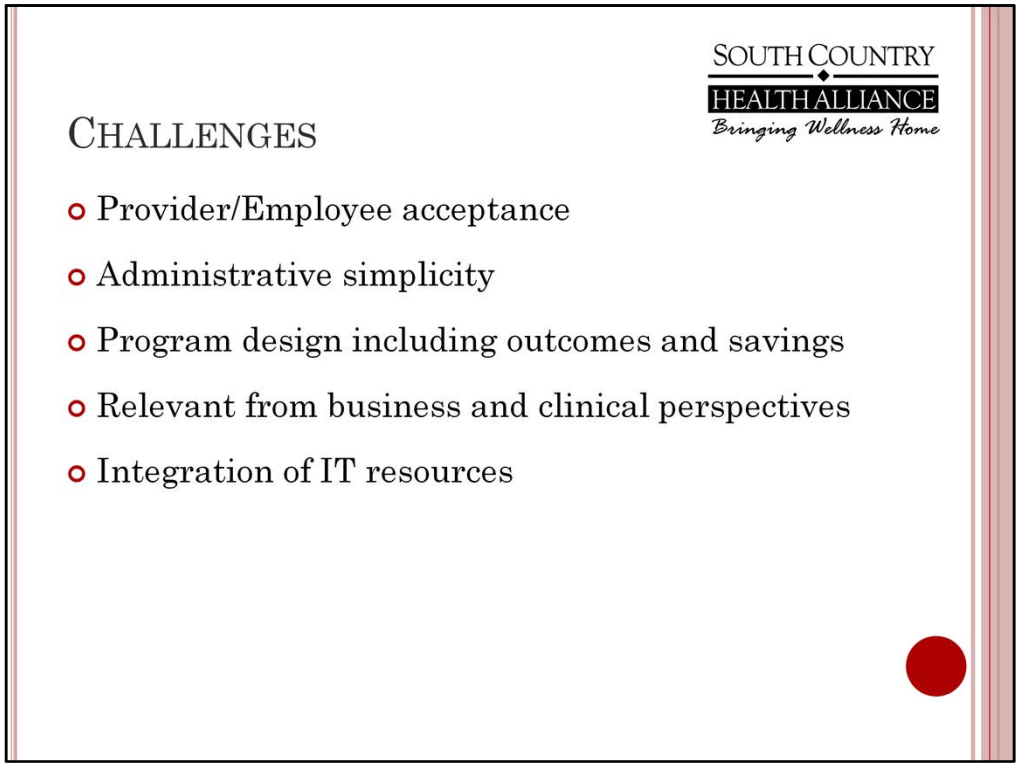


Provider acceptance – start small, pilot programs and educating provider on the benefits of the program

IT Systems to connect – for the evaluation and data collection – if you can get the IT systems to connect – it will greatly improve the relationship and overall success of the program.

Make sure all participants are all on the same page. If one person understands the measure differently it can affect the overall success of the program. Look at leveraging and working together with other organizations, payers, etc…

Make sure to evaluate the program long-term. Long-term outcomes is what will sustain the program.



Nationwide the Long-term benefits and results of value-based agreements remain uncertain. The programs are in the early stages and the stories are largely anecdotal and the data is just starting to emerge.
Mainly focuses on primary care and hospitals but starting to move into other areas.

Main challenges include:

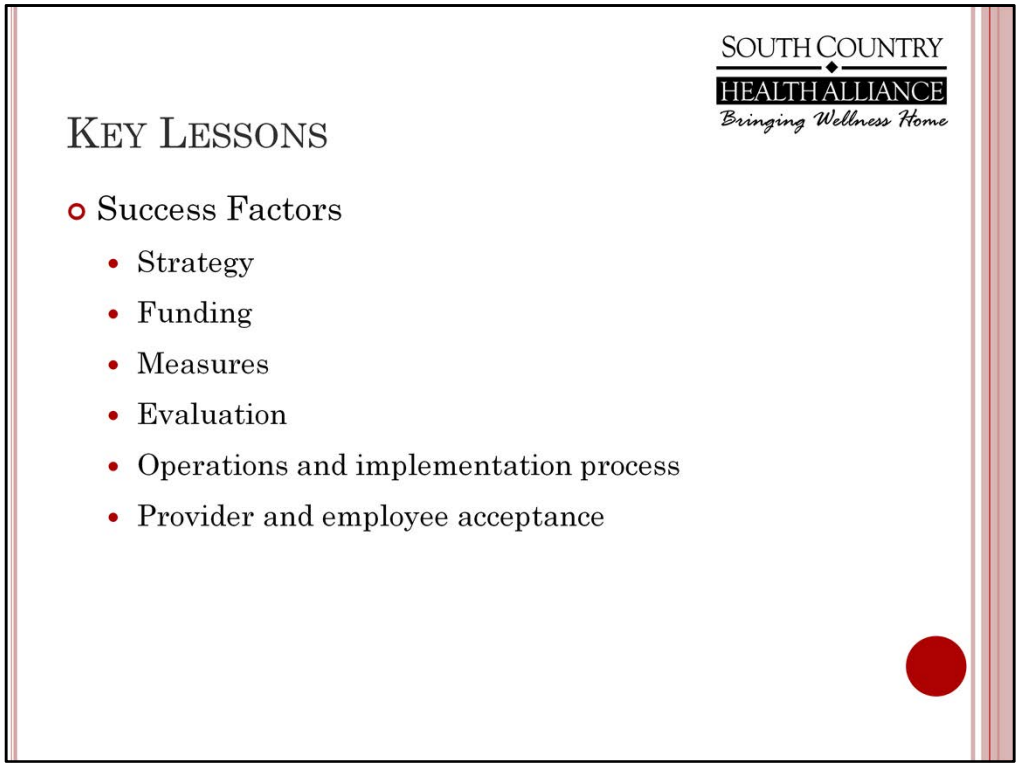
1) buy-in – if providers and/or employees do not accept it will be difficult to be successful.

2) Keep it simple especially at the beginning. Build the success and motivation to be more innovative and more creative.

3) Program design – don't over complicate, make sure that the outcomes and savings are possible to achieve – don't set unreasonable goals, be realistic

4) Relevant – make it meaningful and beneficial to all participants.

5) IT – DATA, DATA, DATA – most administratively burdensome activity. Think of how to make things easier to track, collect, and analyze.



To have a Successful Value-Based purchasing agreement:

1) Strategy – multifaceted quality and cost management strategy. Must be relevant from the business and clinical perspectives.

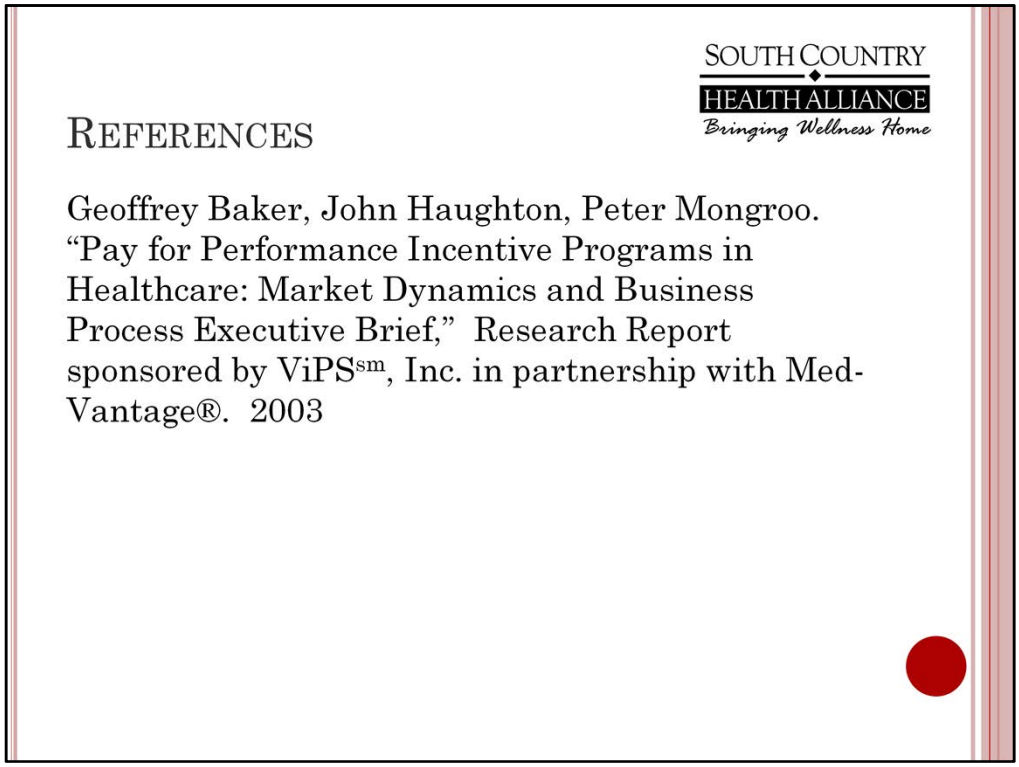
2) Funding – typically through budgeted saving or reallocation of monies. Start-up costs

3) Measures – reflect program goals and be relevant to the program major players. Do not pick measures that make you responsible for results beyond your control.

4) Evaluation – credible results are very important for program success. Program results should be reviewed against cost, efficiency and quality criteria – long-term view is necessary too

5) Operations – not be overly complicated or expensive to administer – well structured and simplified as possible.

6) Provider accept – key to success – start small, provide actionable feedback, relevant to their work do not create extra undue administrative tasks.



This is a publication that I have used and referenced when trying to learn and navigate the world of value-based purchasing.

THANK YOU

Questions???

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