Managed Care
Contracting Strategies
Planning for Value-Based Care Arrangements

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Your presenters

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Value-based care leads to...

Pressure to **Reduce** Cost

Demand for **Increased** Transparency of Quality, Outcomes, & Performance

Migration to a **Patient Centered** Mentality
Transition to a value-based model poses transformational challenges and is one of the greatest financial challenges providers currently face.

**Value-Based Care Model**

- HEALTH PLAN
  - New provider network strategies
  - Operational transformation

- PROVIDER
  - Increased financial risk
  - Changes to care delivery
  - Infrastructure investments

The central goal in healthcare must be value for patients, not access, volume, convenience, quality or cost containment.

\[
\text{Value} = \frac{\text{Health outcomes}}{\text{Costs of delivering the outcomes}}
\]

The “unit of analysis” for VBC is the complete cycle of care for treating a patient's medical conditions or “pre-conditions”.
1.) How would you characterize management’s philosophy towards the shift to value-based payment?

<table>
<thead>
<tr>
<th>Philosophy</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMMITTED</td>
<td>35%</td>
</tr>
<tr>
<td>CAUTIOUS</td>
<td>27%</td>
</tr>
<tr>
<td>SKEPTICAL</td>
<td>38%</td>
</tr>
</tbody>
</table>

2) Does your organization have experience with value-based reimbursement contracts? If so, which one?

<table>
<thead>
<tr>
<th>Experience Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>OTHER</td>
<td>20%</td>
</tr>
<tr>
<td>NONE</td>
<td>34%</td>
</tr>
<tr>
<td>SHARED SAVINGS</td>
<td>20%</td>
</tr>
<tr>
<td>ACCOUNTABLE CARE ORGANIZATION</td>
<td>26%</td>
</tr>
</tbody>
</table>
1) Is your organization currently participating in at least one value-based care incentive program?

- YES, RISK SHARING PROGRAMS: 9%
- YES, REPORTING ONLY: 23%
- YES, GAIN SHARING PROGRAMS: 11%
- YES, BONUS PROGRAMS: 26%
- NO: 31%

2) What is your organization’s primary concern with value-based care programs?

- TOO MANY METRICS: 18%
- NOT MEETING TARGETS: 24%
- IT’S NOT A PRIORITY: 14%
- INSUFFICIENT INTERNAL: 44%

CMS generating market momentum

> Hospital VBC programs have generated the following:
  - 87,000 lives saved
  - 2.1M fewer infections
  - $20B in cost savings

> MACRA is adding physicians to the VBC party
  - Physicians will soon be managing some downside risk
  - This will serve to re-align physician incentives
Coming together to make it work

Initially there will be significant variation in program attributes offered.

Providers need to determine their best VBC measurement pathways.

The market must coalesce toward a level of standardization

Payers need to introduce VBC programs that mirror CMS programs.

Over time, variation will decrease as models rationalize on attributes that demonstrate effectiveness.

Two Payment Options

MIPS
- Less complicated
- Has potential “upside” incentives and “downside” penalties

APM
- More complicated
- Has only “upside” incentives from MACRA
What is at stake...

> VBC: Forces doctors into ever-changing environment that impacts their pocket book and gets their “skin in the game”

> MIPs Payment Adjustment Factor based on relative performance

> Eligible APMs are required to be entities that bear risk in excess of a nominal amount

<table>
<thead>
<tr>
<th>VBP Measures</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Care</td>
<td>30%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Patient- and Caregiver-Centered Experience of Care</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Care Coordination / Person and Community Engagement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety</td>
<td>20%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Efficiency and Cost Reduction</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>QPP Metric</th>
<th>Weight in 2019</th>
<th>Weight in 2020</th>
<th>Weight in 2021 and Beyond</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>60%</td>
<td>50%</td>
<td>30%</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Resource Use</td>
<td>0%</td>
<td>10%</td>
<td>30%</td>
</tr>
</tbody>
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There is some overlap between VBP and QPP.
VBC Program Continuum Provider Perspective

Small % financial risk

Large % of financial risk

Fee-for-value models

Fee-for-service
Pay for performance
Episode based payments
Shared savings (ACOs)
Shared risk (ACOs)
Partial capitation
Full capitation

Limited provider integration

More developed provider integration

VBC Program Continuum Payer Perspective

Right Service

Right Provider

In the Right Model

Payers must choose the right reimbursement model for each of their provider contracts across their network

Fee-for-service
Pay for performance
Episode based payments
Shared savings (ACOs)
Shared risk (ACOs)
Partial capitation
Full capitation
Payer programs can include different metrics:

- Quality Measures
- Outcomes
- Patient Satisfaction
- Cost Measures

And can be structured in many ways:

- BONUS PROGRAMS
- SHARED SAVINGS
- RISK

PROVIDER READINESS
3) Has your organization created a roadmap to transition to value-based care?

- **YES, WE WILL BEGIN EXECUTING THE TASKS IN 2017**: 24%
- **YES, WE HAVE HIRED EXTERNAL ASSISTANCE TO DEVELOP THE ROADMAP**: 9%
- **YES, WE ARE CURRENTLY EXECUTING THE TASKS CONTAINED IN THE ROADMAP**: 26%
- **NO, WE HAVE NOT YET BEGUN ROADMAP DEVELOPMENT**: 41%

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**Keys to VBC contracting success**

**Providers**

- Cross-functional organizational structure
- New skills – predictive analytics, actuarial, patient engagement, provider engagement, IT
- Current performance benchmarks
- Care continuum
- Clinical integration
- Care management
- Provider compensation incentives
VBC contract considerations

> Identify attributed population
  • Population demographics and trends
  • Analysis of historical claims data, EHR data
  • Current performance measurement data
  • Expenses (historical, projected)

> Services, facilities, staffing required

> IT support, infrastructure needed

> Identify upfront costs

Financial considerations

> Contractual payments
  • Payment models
    - Incentives
    - Shared savings
    - Global capitation
  • Payment provisions
    - Phased-in risk
    - Upside/downside risk
    - Targets, metrics
Financial considerations (continued)

> Financial protections
  - Actuarial/predictive modeling
  - Stop-loss insurance, risk limits

> Responsibilities for services
  - Risk distribution
    - Incentives for high-quality, cost-efficient care
    - Equitable and transparent across providers
    - Providers’ payments aligned with contract payments
  - Carve-in/carve-out arrangements
    - High-cost, high-risk services (e.g., organ transplants)
    - Care outside of service area
    - Other services (e.g., behavioral health)

Providers should be aware of how cost is determined

> Cost of care/PMPMs
  - Baseline determined on provider’s historical costs
  - Health plan sets target
  - Clear vision of what is in and out of PMPM
    - Care transition fees, other admin fees, pharmacy, behavioral health

> Excess margin
  - Health plan calculates margin based on provider’s book of business
  - Calculates target margin
  - Provider can share in margin improvement
Program participation

Program progression

- Reporting only to risk sharing
- Usually two to three years
- Start with reporting only to test the waters
  - Understand how program works and how you perform

Negotiable terms

- Negotiate an opt-out if possible and if early results indicate there will be losses
- Negotiate on the measures to be included and the weightings if possible
  - May be offered long list of measures by payer
  - Select those with which the provider will have success
  - May have more direct impact on some measures versus others

Program structure

Providers should be aware of the mechanics of the program and how the calculations are performed to determine results.

- Measures can change year by year
  - How is improvement calculated?
  - Is it based on target or year over year improvement?

- Weightings may vary by category and should focus on highest weights.

- Magnitude of savings potential - % of total payer revenue; in lieu of annual increase

- Population, measures and programs may vary by line of business

- Is your program cost savings dependent?
Internal processes

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<thead>
<tr>
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<tbody>
<tr>
<td>1.</td>
<td>Ensure clinical staff is involved in program development</td>
</tr>
<tr>
<td>2.</td>
<td>Train applicable staff</td>
</tr>
<tr>
<td>3.</td>
<td>Understand financial implications</td>
</tr>
<tr>
<td>4.</td>
<td>Establish a committee to interact with payer and implement improvement plans</td>
</tr>
<tr>
<td>5.</td>
<td>Perform member outreach and engagement</td>
</tr>
<tr>
<td>6.</td>
<td>Explore patient-focused case management opportunities</td>
</tr>
<tr>
<td>7.</td>
<td>Ensure claims and encounters are being coded and submitted appropriately</td>
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Collaborating with payers on programs to improve:

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<table>
<thead>
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</thead>
<tbody>
<tr>
<td></td>
<td>Member outreach</td>
</tr>
<tr>
<td></td>
<td>Case management and training</td>
</tr>
<tr>
<td><strong>Fees for care management/coordination</strong></td>
<td>Are part of some programs for hospitals and physician practice transformation</td>
</tr>
<tr>
<td><strong>Joint operating committees</strong></td>
<td>Establish committee with representatives from provider and payer; include administrative and clinical people</td>
</tr>
<tr>
<td><strong>Detailed reporting</strong></td>
<td>Payers can provide reporting to help identify patients and physicians contributing poor results</td>
</tr>
</tbody>
</table>
Most providers are very dependent on payers for performance updates and results.

I. Develop internal measuring and reporting

II. Measures may be available through CMS

III. Determine timing of reporting: quarterly is preferred, maybe even monthly

IV. Review results with payer rep to understand data and identify opportunities

V. May need to allow access to EHR system by payer

3) Are you actively participating in a data exchange (e.g., state, hospital association, etc.)

- YES, WE ARE SHARING ONLY COST INFORMATION: 5%
- YES, WE ARE SHARING ONLY CLINICAL INFORMATION: 28%
- YES, WE ARE SHARING BOTH CLINICAL AND COST...: 28%
- NO: 39%

4) How would you rate your organization’s efforts to actively engage patients either prior to their visit, during their visit or after their visit?

- POOR: 12%
- SATISFACTORY: 28%
- GOOD: 45%
- VERY GOOD: 15%
Patient engagement is used to describe everything from patient portals to social media strategies, from tracking vitals with wearables to patients actively participating in their own health and wellness.

"The involvement in their own care by individuals (and others they designate to engage on their behalf), with the goal that they make competent, well-informed decisions about their health and health care and take action to support those decisions."

Agency for Healthcare Research and Quality (AHRQ)

Use of Patient Engagement Initiatives to Increase Patients’ Meaningful Participation in Care

- Yes: 69%
- No: 15%
- Not sure: 15%

Is your organization currently using patient engagement tools, programs, or technologies to increase patients’ meaningful participation in their care?

Sample size = 269

Importance of Care Coordinators to Improving Patient Engagement

- Essential: 36%
- Very important: 30%
- Important: 24%
- Not very important: 7%
- Not at all important: 6%

How important are care coordinators to improving patient engagement within a health care organization?

Sample size = 269
Is there an ROI to patient engagement?

Providers agree engagement improves care...but they worry about the cost and lack of reimbursement.

$25k per year per physician

20% more new patients

27% through programs like MIPS

In addition to improving care, there are financial benefits that come from offering the engagement and services patients want.

Sources: Accenture / AARP / CDW / HIMSS / Johns Hopkins / Technology Advice / University of Rochester

Patient Engagement Leads to a Better Experience

The ability to use patient experience as a competitive and strategic differentiator to gain market share is a valuable tool.

Active Shoppers Turning to Familiar Sources

I got sick and needed to see a doctor. Back then there was very little information on the Internet; it was frustrating. We realized the best way to find a doctor, or other services, was by word of mouth.

Jeremy Stoppelman, Yelp Co-Founder

Examples of Topics Covered in Yelp Reviews

- Cost of hospital visit
- Insurance and billing
- Ancillary testing
- Facilities
- Amenities
- Scheduling
- Compassion of staff
- Family member care
- Quality of nursing
- Quality of staff
- Quality of technical aspects of care
- Specific type of medical care

1) Has your organization taken steps to improve existing technology capabilities to support value-based care?

<table>
<thead>
<tr>
<th>Response</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, we have identified necessary improvements and are...</td>
<td>20%</td>
</tr>
<tr>
<td>Yes, we have completed improvement implementation</td>
<td>34%</td>
</tr>
<tr>
<td>Yes, we are beginning to implement improvements</td>
<td>31%</td>
</tr>
<tr>
<td>No, this is planned for 2017</td>
<td>4%</td>
</tr>
<tr>
<td>No, our technology already supports VBC</td>
<td>4%</td>
</tr>
<tr>
<td>No</td>
<td>0%</td>
</tr>
</tbody>
</table>

2) Has your organization developed relationships with providers for services you do not internally provide?

<table>
<thead>
<tr>
<th>Response</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, we have identified necessary additions will begin discussions with those providers in 2017</td>
<td>36%</td>
</tr>
<tr>
<td>Yes, we have identified necessary additions and have completed the relationship development</td>
<td>23%</td>
</tr>
<tr>
<td>Yes, our integrated delivery network includes access to all acute and post acute services</td>
<td>18%</td>
</tr>
<tr>
<td>No</td>
<td>23%</td>
</tr>
</tbody>
</table>
Payer capabilities & transformation

The other side of the coin

> Payers are also grappling with the changes required

> It is no small feat as payers historical operational and technology investments are focused on administering FFS

> Let’s take a glimpse into what you can expect from the payers and the evolution they are undertaking as they move to the value system

> Scenario: ACO Shared Savings – Downside Risk

Key Strategic Challenges

> Defining performance measurement criteria in network contracts
  > Integration of multiple competing models, the right model for the right provider

> Securing on-going reliable, credible, actionable insight during the performance period

> Definition of models mutually agreeable to the objectives of both providers and payers

> Structuring the business design of the reimbursement strategy to address Member Cost Share

> Enabling members to behave in the new model via cost and quality transparency
Key Operational Challenges

- Managing and communicating the organizational change required
  - Recognizing that an operational organization and set of business processes with supporting technology capability is required

- Increasing complexity of the network contracts
  - Placing pressure on the systems to be flexible enough to handle these unique contract terms in a controlled, reliable, auditable way

- Evolving the mindset for data analytics
  - Traditional use of analytics does not include an acceptable level of control to be utilized for financial transaction processing

- Improving transparency with Providers via data sharing agreements
  - Claim and clinical data
  - Timeliness and completeness concerns
  - FFS negotiation impacts

Critical to Making the Shift

- Investing in a new integrated solution
  - The FFV programs have moved from pilots to competitive imperatives targeted to enable network strategies thus requiring an integrated solution.

- Living in the new world built on the old
  - New system solutions are required in the new model. These solutions will be fed by the legacy systems. At the same time, the new model will force changes to the old systems.

- Wielding data in a new way
  - Many times, financial transactions will be generated on the basis of an algorithm, analyzing full performance period worth of data. Therefore, significant focus is required on data quality, acquisition and distribution.
Baker Tilly Solution Framework

Critical Components

- Population Identification
- Cost Efficiency Measurement
- Quality Outcome Measurement
- Provider Analytics
- Financial Settlement
- Care Management Delegation

Central Location to Capture all Populations for Program Administration

- Attribution Models
- Member Self Selection
- Provider Nomination
- **Member Disease States**
- Program Eligibility Rules
- Member Risk Scores

Raw Membership Data

Program Specific Populations
Flexible Framework to Support Program and Contract Specific Models

- Cost benchmark-based targets
- **Cost model-based targets**
- Cost target to actual measurement
- Utilization metric driven performance measurement
- **Care pathway adherence**
- Episodic performance
- Population ID integration

‘The Right Model for each Program (and Provider)’

Deploy Quality Rules Engine Against Program Specific Populations

- **Quality rules engines**
- Clinical data integration
- Quality benchmark-based targets
- Quality model-based targets
- Quality target to actual measurement
- Population ID integration

Integrate Industry Standard Rules Engines As Needed
Generate Analytics to Support Achievement of Program Objectives

- Raw data sharing
- Interim & final cost performance reporting
- Interim & final quality performance reporting (including Care Gaps)
- **Opportunity reporting – actionable, member level**
- Clinical data integration
- Population ID integration

Collaboration on Analytics that Help Drive Performance

Measurement Results Integrated into Settlement Transactions

- Incentive & care coordination transactions
- Non-claim provider payments
- Premium pricing integration
- ASO account billing
- **Member cost share considerations**
- Population ID integration

MAR Ready Financial Transaction Processes
Shift Care Management Relationship to Program Providers

- Agreement management
- **Payer medical management services shutoff**
- Account billing integration
- **Compliance reporting**
- Population ID Integration

Support Clinical Relationships at Point of Care

What can providers expect from their payer partners?

- Program Populations
- Claims History
- P & D T

Cost & Utilization Efficiency
Opportunity Identification
Quality Care Gaps
Cost & Quality Performance Measurement
VBC IS SAVINGS LIVES...

...WHILE SAVING THE SYSTEM
Key Takeaways

Transform your organization for value-based care

1. Providers must be aware of VBC program mechanics
2. Providers should collaborate with payers to improve program performance
3. Payers must tackle legacy systems and implement new enabling technologies
4. Care teams and patients need to communicate in a more continuous way
5. Patient experience is a competitive and strategic differentiator
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