Health Care’s Value-Based Environment
Strategies For Behavioral Health Organizations in New York

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Discussion Agenda

I. The national trends shaping the health care environment – population health, integrated care coordination, and value-based payment models

II. The range of reimbursement options in value-based payment arrangements

III. The opportunities for community-based organizations to participate in VBP with health plans, ACOs, DSRIPs, IPSs, and other partners

IV. The strategic challenges of transformation to a value-based health and human service system
The Drivers of Population Health

**The Affordable Care Act** Under reform, higher proportion of population insured, with no preexisting condition or lifetime limit exclusions – changing the population previously insured

**Health Care Cost Distribution** High-needs, complex consumers are 5% of the population and use 50% of resources – changing the distribution of spending in the population

**Payment Reform** The volume-maximizing incentives built into the traditional fee-for-service environment have been a challenge to maximizing value – and are being replaced with value-based reimbursement arrangements focused on populations rather than individuals
Behavioral Health System Optimization Is Central To Successful Population Health Management

Consumers with behavioral disorders are often ‘superutilizers’ of health care resources.

Lack of integrated care coordination – addressing the medical, behavioral, and social needs of consumers - results in poorer outcomes and higher cost per consumer.

Undiagnosed and/or untreated behavioral health conditions hinder the treatment of a wide range of medical conditions.

Consumers with behavioral disorders and comorbid chronic medical conditions have higher average costs than those consumers without comorbid conditions.
Consumers With Behavioral Disorders Are Often ‘Superutilizers’ Of Health Care Resources

- 5% of Americans consume half of all health care resources
- Much of this is due to frequent and preventable use of expensive health care settings
- This group of consumers is often referred to as “superutilizers” - individuals with multiple illnesses whose care is uncoordinated and fragmented, resulting in high resource use

Superutilizer Facts

- More than 80% of Medicaid superutilizers have a comorbid mental illness
- In 44% of Medicaid superutilizers, mental illness is in the form of an SMI
Consumers With Behavioral Disorders & Comorbid Medical Conditions Have Higher Average Costs

- Mental health and addictive disorder comorbidities increase average health care costs by up to 200%
- Individuals with these comorbidities often experience gaps in care management, leading to avoidable utilization of expensive health care settings

<table>
<thead>
<tr>
<th></th>
<th>Asthma &amp;/Or COPD</th>
<th>CHF</th>
<th>CHD</th>
<th>Diabetes</th>
<th>Hypertension</th>
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</table>
Undiagnosed & Untreated Behavioral Health Conditions Hinder Treatment Of Medical Conditions

- Each year, one in four Americans experience some mental illness\textsuperscript{14}
- The presence of a mental health or addictive disorder comorbidity can increase a person’s chances of hospital admissions by up to 300\%\textsuperscript{13}
- When individuals receive fragmented care, their comorbid health problems can go untreated, leading to a cycle of reliance on emergency room and inpatient hospital stays\textsuperscript{13}

Example: Impact Of Depression

- 2/3 of depression cases go undiagnosed in primary care settings.\textsuperscript{15}
- Mood disorders like depression are the third most common cause of hospitalization among nonelderly adults\textsuperscript{14}
- 60\% of individuals suffering from chronic depression have not received treatment within the last year.\textsuperscript{14}
What Is Best Practice In Integrated Care Coordination?

Old Model
- Medical
- Behavioral
- Social

New Model
- Person-centered care coordination program for each consumer

Value-based reimbursement models needed to optimize integrated care coordination
## More Managed Care In The Health Care Landscape

### U.S. Managed Care Penetration By Payer, 2016

<table>
<thead>
<tr>
<th>Payer Segment</th>
<th>Total U.S. (Million)</th>
<th>Percent U.S. Population</th>
<th>Managed Care Enrollees (Million)</th>
<th>Percent In Managed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>56.5</td>
<td>17.5%</td>
<td>17.3</td>
<td>30.5%</td>
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<tr>
<td>Medicaid*</td>
<td>72.4</td>
<td>22.4%</td>
<td>45.4</td>
<td>62.7%</td>
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<tr>
<td>Military</td>
<td>4.8</td>
<td>1.5%</td>
<td>4.8</td>
<td>100%</td>
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<tr>
<td>Commercial</td>
<td>160.5</td>
<td>49.7%</td>
<td>159.0</td>
<td>99.1%</td>
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<tr>
<td>Uninsured</td>
<td>28.6</td>
<td>8.9%</td>
<td>0.0</td>
<td>0.0%</td>
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<tr>
<td>TOTAL</td>
<td>323.0</td>
<td>100%</td>
<td>226.5</td>
<td>70.2%</td>
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</table>

*Medicaid enrollment includes the Medicare/Medicaid dual eligible population*
New Enrollment & New Populations

Increasing Use Of Managed Care Financing & Service Delivery Models

• Commercial
• Medicaid
• Medicare
• Dual eligible

New Populations

• Complex disabilities
• Long-term care
The Increasing Use of Accountable Care Organizations

Currently there are over 800 public and private ACOs in all 50 states, the District of Columbia, and Puerto Rico

- 436 Medicare ACOs
- 316 Commercial ACOs
- 62 Medicaid ACOs

25-31 million Americans (17% of the population) receive care through ACOs

- 2.4 million in Medicare ACOs
- 15 million non-Medicare patients in Medicare ACOs
- 8-14 million patients of non-Medicare ACOs

67% of Americans live in an area with ACO coverage
Transition Of Payment To Provider Organizations From Volume To Value

Compensation Continuum By Level Of Financial Risk

In 2014, about 40% of commercial health plan reimbursements to provider organizations were linked to value-oriented initiatives.\(^2\)
What Are the Pay-For-Value Reimbursement Options?

- Case rates and bundled rates
- Medical homes and specialty medical homes
- Capitation and/or population health gainsharing arrangements

With Pay-For-Performance Components

Specialist positioning

Comprehensivist positioning
Managed Fee-For-Service

Provider paid an established fee for a defined service

- Clearly defined package of services to be provided
- Quality standards can be established for defined services

Varying degrees of ‘management’

- Preauthorization
- Concurrent review
- Retrospective review
Case Rates, Bundled Rates, Episodic Payments

### Case Rates

Payment of a flat amount for a defined group of procedures and services

- Per treatment episode
- Per time period

Based on:

- Diagnosis or functional status
- Other consumer characteristics
- Package of services included
- Length of time
Capitation In Population Health Arrangements

### Capitation/Subcapitation

A contracted rate for each member assigned, known as the "per-member-per-month" (PMPM) rate

| Regardless of the number or nature of services provided | Contractual rates are usually adjusted for age, gender, illness, and regional differences |

### Population Health Capitation

- **Behavioral Health Carve-Out Capitation**
  - PMPM for behavioral health treatment benefits (or other cognitive disability support services)

- **Medical Home/Health Home Capitation**
  - PMPM to cover the cost of care coordination and preventative services

- **Primary Care Capitation**
  - PMPM for primary care services (assess, prescribe, refer)

- **Global Capitation**
  - PMPM for cost of delivering all (or some) of the care for a group of consumers
Pay-for-Performance or P4P

Payment systems that offer financial incentives based on achieving particular performance measures

- Focus on specified quality, cost and other benchmarks
- Incentives paid for to achieve, improve or exceed performance benchmarks
- Can be applied to any payment system – FFS, case rates, capitation

Typical P4P criteria

- Hospital readmissions
- Emergency room utilization
- Continuing of care via follow-up after inpatient treatment
- Tenure in the community
- Access to care – in days to request
- Consumer engagement and treatment plan/medication adherence
- Reduced overall health care spending
The Opportunities for CBOs Are Many. . . .

<table>
<thead>
<tr>
<th>Specialty care coordination for consumers with behavioral disorders</th>
<th>Behavioral health service system sub-capitation</th>
<th>Management of specific acute episodes or chronic conditions via case rate or episodic/bundled payment</th>
<th>Behavioral health consultation in office-based service locations – live or via telehealth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home-based service delivery</td>
<td>Specialty ‘center of excellence’ programs for acute conditions</td>
<td>Psychiatric consultation – live or via telehealth – in hospital emergency rooms</td>
<td>Management of short-term inpatient psychiatric and addiction treatment programs</td>
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<tr>
<td>Behavioral health consultation program for inpatient programs</td>
<td>Hospital diversion programs</td>
<td>Specialty behavioral health ER/crisis stabilization</td>
<td>Hospital readmission prevention programs</td>
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<tr>
<td>Community-based/mobile crisis response</td>
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Specialty Care Coordination For Consumers With Behavioral Health Disorders
Beth Israel Deaconess Medical Center
Boston, Massachusetts

Description: This program aims to improve person-centered care coordination for high-needs consumers – and includes within that population, individuals suffering from addiction and mental health problems. Beth Israel Deaconess Medical Center partners with a local CMHC to address co-occurring mental health diagnoses to improve addiction therapy outcomes. A psychiatrist and psychologist manage a team of nurse practitioners and community outreach workers to provide seamless care management and treatment of addictions and behavioral health problems following an ER visit. The care management team provides patients and their families with access to a stable system of medical and social supports including social service providers and faith based organizations.

Target Patient Population: Frequent E.R. users with chronic conditions or with addiction and/or mental health diagnoses.

Performance Data: This program is funded by a grant which will track performance data. Within the first year of operation, the Medical Center has seen improvements in quality and health outcomes.
Specialty Care Coordination For Consumers With Behavioral Health Disorders
State of Missouri Medicaid Program

**Description:** State of Missouri implementation of health home program to provide structure for CMHCs and FQHCs to serve high-needs population. Services include wellness related treatment planning, support in managing chronic health conditions and assistance in accessing primary care.

The program became operational in January 2012 and included 27 CMHC organizations. Within 18 months, enrollment grew from 15,815 to 18,408. They demonstrated consistent improvement in DM quality measures, including reducing hospital admission rates by 12.8%, and emergency room rates by 8.2%. The comprehensive care coordination services are financed by a bundled fee paid PMPM, and includes performance bonuses based on quality outcomes. Services provided outside of the care coordination activities are billed separately.

**Target Patient Population:** Consumers with SMI diagnosis; MH/SA dual-diagnosis; or MH condition and/or SA disorder plus 1 other chronic health condition.
Outpatient Medication-Assisted Addiction Treatment Via Case Rate
BioCare Recovery
Philadelphia, Pennsylvania

Description: BioCare Recovery is an addiction treatment program that combines MAT with individual, family, and group counseling sessions – over no pre-determined timeframe (average length of engagement is 13 months, with utilization of services ranging from 4-18 times per month). The program focuses on adherence to treatment and allowing consumers to step down their addiction treatment – from inpatient to residential to partial hospitalization to outpatient – to one encounter a month. If a relapse seems likely or happens, services can once again be ramped up to the appropriate level. Focusing on adherence in this model is important, because as consumers step down their need for treatment, more and more of them disengage. In response to that disengagement, BioCare created a model that spans the intensive outpatient to general outpatient continuum with an individualized treatment plan for each consumer combining MAT and the counseling services, and the number of hours that a patient receives services depending on their treatment needs. Services can be dialed up or dialed down within 24 hours, depending on where the consumer is in their recovery or if they’re experiencing external factors that might lead to relapse. The goal is freedom from substances.

Target Patient Population: Consumers with opioid and/or alcohol addiction

Performance Data: 90% of participants in the program complete medically managed outpatient detoxification.

BioCare Recovery began as a private pay organization, but now has a case rate contract with Optum Behavioral Health.
Home-Based Geriatric Post-Acute Service Delivery
Summa Health System
Akron, Ohio

Description: Care management strategies for the frail and elderly must consider the unique health risks and problems experienced by this population. A patient-centered approach to care management for the frail and elderly requires subtle differences in care team structures and clinical decision-making. The Summa Health features multidisciplinary care management teams which meet in-person on a weekly basis to discuss patient needs. These teams include physicians, geriatricians, palliative care specialists, RNs, pharmacists, social workers, care managers, and representatives from the local Area Agencies on Aging. Unlike other programs that attribute eligible individuals based on various risk stratification measures, patients in this program are attributed solely through physician referral at the time of discharge. Patients are provided in-home visits and patient preferences for treatment are carefully recorded to assure patient autonomy during care management.

Target Patient Population: Frail and elderly individuals discharged from Summa Health inpatient settings.
Depression Screening & Treatment
In Primary Care Settings
New York City + Hospitals
New York, New York

Description: New York City Health + Hospitals is an 11-hospital health system. Its integrated behavioral health model has been effective within each of its hospitals and in 6 CMHCs. Patients are provided systematic screenings and treatment for depression within primary care settings. All adult patients are screened using a standardized questionnaire. This screening accompanies the vital signs assessment (such as blood pressure monitoring) that takes place at each visit. A team-based approach assures that patients who screen positively for depression receive a warm handoff to a depression clinic, where health improvement goals are set where psychiatric practitioners continue treatment.

Target Patient Population: The program is payer agnostic and is universally applied to all adult patients at each visit.

Performance Data: In 2015, 225,000 patients were screened, 15,000 of which were screened positive for depression. Among patients screened positive and treated within the first quarter of 2016, 57% showed clinical improvement.
Hospital Diversion Program
PinnacleHealth
Harrisburg, Pennsylvania

Description: PinnacleHealth is one of five South Central Pennsylvania health systems that have formed a collaborative to improve care for superutilizers. To decrease ER and inpatient utilization among this population, the health system identified individuals who had experienced 2 or more inpatient stays or 6 or more E.R. visits within 6 months. When they mapped the results, they found that the majority of individuals in this population resided in just three zip codes – two of which were home to long term care nursing facilities. The health system responded by opening clinics within these facilities to take care management to the patient’s residence. Intensive outpatient-based care management included in-home visits and regular phone calls to patients, as well as coordinating transportation to and from appointments. Health improvement goals were created for each patient. Once those goals were met, they were graduated to a lesser intensive form of ongoing care management.

Target Patient Population: Superutilizer patients experiencing 2 or more inpatient stays or 6 or more E.R. visits within 6 months.

Performance Data: Within the first year of this 5 health system collaboration, 138 patients had been enrolled into superutilizer care management and had been graduated to ongoing, less intensive care management once their health improved. A total cost reduction of over $1 million in inpatient and E.R. costs was achieved for these patients.
Specialty Behavioral Health ER/Crisis Stabilization
David Lawrence Center
Naples, Florida

Description: Crisis Stabilization Services available 24 hours a day, 7 days a week for emergency mental health and substance abuse needs. The Adult Crisis Stabilization Unit consists of 28 adult beds of non-hospital, inpatient mental health services that provides brief voluntary and involuntary evaluation individuals experiencing a psychiatric crisis. A separate 4-bed unit is available for children experiencing a psychiatric crisis. Patients are received and discharged to the community without entering high-cost hospitalization services.

Target Patient Population: Adults and children who meet the criteria for crisis stabilization services under the Florida Mental Health Act. The crisis stabilization is funded by a per diem with maximum bed-day rates.
**Hospital Readmission Prevention Programs**

**Legacy Health System**
Portland, Oregon & Vancouver, Washington

**Description:** This program streamlines transitions from acute care to outpatient-based care management by enhancing electronic communication, integrating clinical workflows, and instituting accountability on both hospital and outpatient staff to assure standardized transitions. When a patient is discharged from the hospital, the hospital’s EHR system produces standardized reports including a discharge summary that is sent to primary care providers and relays patient diagnoses, procedures, medication changes, and discharge condition. Clinical teams are notified of discharges in real-time and patients are triaged for vary degrees of follow-up care based on risk factors identified within their electronic health record. Clinical teams then formulate individualized care management plans informed by each individual’s risk factors.

**Target Patient Population:** Medicaid or dual-eligible individuals who experience an inpatient or E.R. hospital visit and are then discharged.

**Performance Data:** This standardized report has improved adherence to follow-up care following a discharge. It has also improved data transparency and communication between the hospital and each patient’s primary care physician.
**Service Delivery Winners**

- Case rate/bundled rate service programs for acute and chronic conditions
- Tech-enabled, hybrid service delivery – BYOD in any location
- Programs with superior consumer experience, including web-enabled organization interfaces
- Professional “lifestyle” practices
- “Top of practice” delivery models
- Decision support and process excellence
- Any service – medical, behavioral, social – with demonstrated ROI and VBP reimbursement

**Service Delivery Losers**

- Provider organizations with poor consumer interface (access, experience)
- High unit cost services without ‘value’ equation
- Long-term outpatient services except in EBP
- Hospital and residential treatment, overall
- Office-based services without tech-enabled consumer link
- Solo practice, except for cash
Business Model Transition For Provider Organizations

**Payer Policy**
Pay-For-Cost/Volume

**Business Model:**
What is paid for is good for the consumer and is doing more

**Payer Policy**
Pay-For-Value

**Business Model:**
Giving the consumer (and their payer) good outcomes at a low cost, conveniently

A Revolution In Performance Management Required
Implications Of Transitioning From Volume To Value Payments For Provider Organizations

- Develop organizational competencies and culture to compete in a performance-based world
- “Braid” health and social support to achieve cost effective outcomes
- Improve understanding of cost drivers – administrative, clinical, and in population resource use
- Strengthen financial position and financial management capabilities
- Prepare for “narrowing” of provider networks due to risk-based contracts
How To Maintain Competitive Advantage & Financial Sustainability? Three Strategic Questions

What is your organization’s “vertical strategy” to engage emerging consumer care coordination organizations and consolidation among purchasers?

What is your “next generation” service line?

How does your organization create that “next generation” service line and stay a market leader?
**Question #1: What Is Your Organization’s “Vertical Strategy” To Engage Emerging Patient Care Coordination Organizations?**

<table>
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<tr>
<th>Structural Positioning Options</th>
<th>Reimbursement Options</th>
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<td>ACO/MCO Partner (FFS P4P Or Risk-based)</td>
<td>FFS, FFS with P4P, Case Rate, Episodic/Bundled Payment, Capitation</td>
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<td>Specialty ACO/MCO Provider Or Partner</td>
<td>FFS, FFS with P4P, Case Rate, Episodic/Bundled Payment, Capitation</td>
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<td>Medical/Health Home Provider</td>
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<td>Medical/Health Home Partner</td>
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<td>Case Rate-Reimbursed Specialty Program (By Population)</td>
<td>Case Rate, Episodic/Bundled Payment,</td>
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<td>High-Performing Network Provider And/Or “Center Of Excellence”</td>
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<td>Network Provider</td>
<td>FFS</td>
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Question #2: What Is Your “Next Generation” Service Line?

### Characteristics Of The “Next Generation”

- Demonstrate better outcomes and reduced resource use – to support competitive value proposition and marketing
- “Plug into” patient care coordination initiatives – to increase reimbursable consumer population
- Accept value-based reimbursement: risk-based and/or P4P – to attract payer
- Deploy new neurotech advances - for better outcomes and improved consumer preference
- Embrace consumer self-service technology - to reduce costs and improve consumer engagement
- Incorporate e-health and remote monitoring - to lower labor costs and improve consumer preference
- Use analytics-based decisionmaking – to optimize organizational planning, consumer care management, and financial management
Question #3: How Does Your Organization Select That “Next Generation” Positioning & Service Line - To Stay A Market Leader?

- Core Competency Assessment
- Tech Deployment
- Competitive Analysis
- Organizational Asset Assessment

Adopt disciplined ‘rules’ for new service line development.
The Realities Of An Organization’s Assets Available For Repositioning & Reinvention

1. Historical mission and vision – organizational charter
2. Regulatory limitations
3. Competition in market
4. Management team competencies and expertise
5. C-suite executive leadership qualities
6. Organizational culture
7. Financial resources
8. Time

This assessment – core competencies, competitive benchmarking, and organizational assets – should drive decision making about strategic advantage and positioning.
Turning market intelligence into business advantage

OPEN MINDS market intelligence and technical assistance helps over 140,000 mental health executives tackle business challenges and maximize organizational profitability.

Chronic Care Management • Disability Supports & Long-Term Care • Mental Health Services • Addiction Treatment • Social Services • Intellectual & Developmental Disability Supports • Child & Family Services • Juvenile Justice • Adult Corrections

Health Care
Appendix – To Add As Needed
NYS’ Delivery System Redesign Incentive Program (DSRIP) To Restructure The Health Care Delivery System

**Goals**

- Promoting community-level collaborations
- Reducing avoidable hospital use by 25% over 5 years
- State committed to 80% VBP by end of waiver period
- Over 500 stakeholders participating in implementation

**Performing Provider Systems (PPSs)**

- 25 PPSs established statewide
- PPSs implement innovative projects focused on:
  - System transformation
  - Clinical improvement
  - Population health
New York State DSRIP Themes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Value Focus</th>
<th>Reward</th>
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</thead>
<tbody>
<tr>
<td>Value Over Volume</td>
<td>Move focus from volume of services to outcomes</td>
<td>Reward safety net providers for better outcomes – move sustainability focus from volume of services that don’t result in value</td>
</tr>
<tr>
<td>Stronger Together Than We Are Apart</td>
<td>Move focus from siloed services to integrated treatment</td>
<td>Reward providers for coming together to produce better patient outcomes</td>
</tr>
<tr>
<td>Reducing Avoidable Complications and Hospital Use</td>
<td>Move focus from emergency treatment in the most costly settings, to maintenance of health in the community</td>
<td>Reallocate funding to community based services</td>
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<tr>
<td>Reinvesting In The System</td>
<td>Move focus to measuring and demonstrating better outcomes</td>
<td>Enable providers to move from financial distress to increased margins by demonstrating results</td>
</tr>
<tr>
<td>Making Health Care Sustainable</td>
<td>Move financial resources where they are needed the most to address financial distress of community providers</td>
<td>Create financial resources for a sustainable future</td>
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</table>
NYS Value-Based Payment Options

Flexibility to determine the value-based payment option that best fits strategy, local context and ability to manage innovative payment models

- Total Care For The Total Population
- Integrated Primary Care
- Selected Care Bundles
- Special Needs Subpopulations
MCO Contracts With PPS For PMPM For Total Population & Overall Outcomes Of Care

- Significant opportunities to reduce costs and improve quality
- Population attributed to geography and service area – need to address service area needs
- Requires PPS/Provider experience with capitated contracting
MCO Reimburses Based On Savings & Quality Outcomes Achieved

- MCO contracts with the PPS
  - Patient-Centered Medical Home (PCMH)
  - Advanced Primary Care (APC)

Focus on "downstream" costs – expenditures are reduced while primary care is effective

Eliminating avoidable ED visits and hospital admissions

Quality outcomes related to integrated primary care, including behavioral health and other chronic conditions
MCO Contracts For Specific Patient-Centered Bundles Of Care With The PPS

**Selected Care Bundles**

**Acute Bundles of Care**
- Associated with a specific illness, medical event, or condition - payment bundles based on the time-limited illness or event

**Chronic Bundles of Care**
- Associated with chronic conditions – payment bundles created around “full-year-of-care”
MCO Contracts With PPS For Care of Subpopulations With Comorbidity Or Disability

Similar to a capitated model – PMPM for a specific special needs population

The state has identified specific special needs populations like

- Managed Long-Term Care
- Developmental Disabilities
- HIV/AIDS
## Provider Opportunities In Response To Value-Based Reimbursement

### Collaboration
- Participation in PPS to address:
  - Avoidable hospitalizations through population management and care coordination
  - Reduction in key HEDIS measures – 30, 60 day hospital readmissions

### Integration
- Participation with Primary Care
  - Co-location
  - Collaboration

### Merger
- Vertical Integration – utilize organization to provide comprehensive services
- Horizontal Integration – utilize size to leverage resources and infrastructure
Opportunities Focus On Reduction Of Health Care Costs & Integrated Care Models

- Models of integration with primary care
- Operation of health homes and care coordination presents opportunity for diversification of provided services
- Behavioral health providers will need to determine interest in and ability to become a network provider for ACOs
- ACOs and Federally Qualified Health Centers (FQHCs) are attracted to community mental health centers that often possess competencies and offer a continuum of services
What Does A Health Plan Want From A Provider?

Improved member care experience
- Focus on the patient/member needs, not the provider needs
- Coordinated system with less fragmentation
- Less inpatient care
- Integrated community-based care

Change in system focus
- From a reactive provider-focused system, to a proactive patient/member focused system

Collaborative process
- With payers and other providers

Provider networks focused on performance standards
- Funding tied to mutually established goals
- Provider incentives aligned with service goals

Focus on increasing value
- Patients/members
- Community
- Other stakeholders
## Getting “Preferred” Provider Status: Show Collaborative Behaviors

<table>
<thead>
<tr>
<th>Instruction</th>
<th>Description</th>
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<tr>
<td><strong>Educate your medical colleagues and allow them to educate you</strong></td>
<td>- Identify integrated strategies – health homes, co-located services with primary care</td>
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<tr>
<td><strong>Be willing to share new ideas</strong></td>
<td>- Identify new solutions and share them with payers</td>
</tr>
<tr>
<td><strong>Share your data</strong></td>
<td>- Show health plans the data you’re tracking to drive performance</td>
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</tbody>
</table>
| **Volunteer to pilot programs** | - Small pilots test new ideas and programs  
- Participating in a pilot creates opportunities to be part of long-term solutions |
Succeeding In The New Value-Based Purchasing Environment

1. Know your costs
2. Create systems to track performance in real-time
3. Implement a continuous process improvement framework
4. Develop superior contracting skills
5. Identify ways to collaborate and provide seamless services
NYS Value-Based Payment Options

Flexibility to determine the value-based payment option that best fits strategy, local context and ability to manage innovative payment models

Total Care For The Total Population
Integrated Primary Care
Selected Care Bundles
Special Needs Subpopulations
MCO Contracts With PPS For PMPM For Total Population & Overall Outcomes Of Care

Total Care For The Total Population

Significant opportunities to reduce costs and improve quality

Population attributed to geography and service area – need to address service area needs

Requires PPS/Provider experience with capitated contracting
MCO Reimburses Based On Savings & Quality Outcomes Achieved

MCO contracts with the PPS

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Focus on "downstream" costs – expenditures are reduced while primary care is effective

Eliminating avoidable ED visits and hospital admissions

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• Associated with chronic conditions – payment bundles created around “full-year-of-care”
MCO Contracts With PPS For Care of Subpopulations With Comorbidity Or Disability

Similar to a capitated model – PMPM for a specific special needs population

The state has identified specific special needs populations like
- Managed Long-Term Care
- Developmental Disabilities
- HIV/AIDS
Provider Opportunities In Response To Value-Based Reimbursement

<table>
<thead>
<tr>
<th><strong>Collaboration</strong></th>
<th><strong>Integration</strong></th>
<th><strong>Merger</strong></th>
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<td>• Participation in PPS to address:</td>
<td>• Participation with Primary Care</td>
<td>• Vertical Integration – utilize organization to provide comprehensive services</td>
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<td>• Avoidable hospitalizations through population management and care coordination</td>
<td>• Co-location</td>
<td>• Horizontal Integration – utilize size to leverage resources and infrastructure</td>
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<tr>
<td>• Reduction in key HEDIS measures – 30, 60 day hospital readmissions</td>
<td>• Collaboration</td>
<td></td>
</tr>
</tbody>
</table>
Opportunities Focus On Reduction Of Health Care Costs & Integrated Care Models

Models of integration with primary care

Operation of health homes and care coordination presents opportunity for diversification of provided services

Behavioral health providers will need to determine interest in and ability to become a network provider for ACOs

ACOs and Federally Qualified Health Centers (FQHCs) are attracted to community mental health centers that often possess competencies and offer a continuum of services
What Does A Health Plan Want From A Provider?

Improved member care experience
- Focus on the patient/member needs, not the provider needs
- Coordinated system with less fragmentation
- Less inpatient care
- Integrated community-based care

Change in system focus
- From a reactive provider-focused system, to a proactive patient/member focused system

Collaborative process
- With payers and other providers

Provider networks focused on performance standards
- Funding tied to mutually established goals
- Provider incentives aligned with service goals

Focus on increasing value
- Patients/members
- Community
- Other stakeholders
Getting “Preferred” Provider Status: Show Collaborative Behaviors

- **Educate your medical colleagues and allow them to educate you**
  - Identify integrated strategies – health homes, co-located services with primary care

- **Be willing to share new ideas**
  - Identify new solutions and share them with payers

- **Share your data**
  - Show health plans the data you’re tracking to drive performance

- **Volunteer to pilot programs**
  - Small pilots test new ideas and programs
  - Participating in a pilot creates opportunities to be part of long-term solutions
Succeeding In The New Value-Based Purchasing Environment

- Know your costs
- Create systems to track performance in real-time
- Implement a continuous process improvement framework
- Develop superior contracting skills
- Identify ways to collaborate and provide seamless services
Size Alone Is Not A Strategic Solution & Not The Only Driver

Larger organizations can spread the “overhead costs” for technology, financing expenses, compliance, marketing, legal counsel, and other core competencies over a larger revenue base – which in many cases gives them a lower unit cost.

However, not all of the “large” organizations that are a result of these mergers and acquisitions are doing well – either from a service delivery perspective or a financial perspective.
Consolidation As A Strategic Issue

Doing more of a service that is losing money won’t necessarily make it profitable.

- Being big in this instance is only useful if it’s part of a strategy to reduce service cost or gain market clout to raise pricing
- If the size doesn’t come with enough economies of scale to reduce the effective cost of service, the strategy won’t work

Adding services and programs unrelated to mission or key objectives could result in more problems for marketing and management.

- Being big can’t only be about a number
- Some organizations in the field are big but not sustainable because they are diversifying without a strategic plan

Increasing size may negatively impact the ability to innovate or adapt.

- Being big has a disadvantage – big is rarely nimble
- Larger organizations can be slow to change course, and in a market filled with policy changes, technology innovations, and shifting payment and service delivery models – the ability to adapt is a necessity
Notable Mergers In Past Year

- Aetna/Humana and Anthem/Cigna
- Providence (Seattle) and St. Joseph Health (Orange Cty CA) merge – created $100 million mental health organization
- Centerstone/WellSpring and Centerstone/Seven Counties
- Molina Acquires Providence Human Services to Create “Pathways”
- Acadia acquisitions – 25 acquisitions since 2011 - Highland Hospital, Belmont Behavioral Health, Ochsner Partnership, 6 UK facilities
Risk-Based & Value-Based Reimbursement & Payments

- Receipt and reconciliation of value-based payments in many forms
- Ability to pay contracted providers using value-based reimbursements
- Encounter reporting: reporting granular utilization data to payers
- Reconciliation of capitation payments against enrollment data files
Consumer-Facing Operations Management

- Client portal
- Automated (self-service) customer service functionality
- Streamlined eligibility determination process
- Support of live customer service inquiries
- Appeals and grievance processes
- Care and service referral process
- Social service database and referral process
- Mobile health applications (e.g. smart phone apps)
- Nationally recognized client satisfaction surveys
Provider Network Management Functionality

Provider network analytics to identify gaps in care

Provider claims payment

Provider performance measurement tools for network optimization
Utilization Management Functionality

- Utilization management system and supports

- Risk stratification tools – including consumer assessment, cross-system data sharing, etc.

- Population health analytic capabilities

- Identify gaps in care delivered compared to clinical guidelines and deploy interventions designed to increase guideline compliance.
Care Coordination Competencies

- Data system to promote real-time data sharing and care coordination between all professionals participating in a consumer’s care
- Health information exchange capability with ‘non-system’ professionals and providers
- Decision support tools to promote the use of evidenced-based practices
- Consumer engagement strategy and related tools
Financial Management Functionality

Ability to estimate and manage total cost of care for populations served

Has tools, expertise and capacity to accept risk and potential cash flow needs

Coordination of benefits: dual eligible population, other populations with dual coverage
Sources Of Capital For Development

- **Borrowing**
  - Asset-based loans - sale/leaseback of real estate, information systems or vehicles
  - Small business loans
  - Lines of credit
- **Real estate investment trusts (REITs)**
- **Sale of accounts receivable**
- **Divestiture of a service line or asset for proceeds**
- **Intellectual property licensing “franchise”**
- **Private family trust investment and/or gift**
- **Grants - both corporate and government (non-profit only)**
- **B Corporation or Benefit corporation – only in some states**
- **Investors (for-profit only)**
  - Angel investors
  - Venture capitalists
  - Boutique investment banks
  - Private equity firms
- **Bond financing (for 501(c)(3) non-profits only)**
- **Social impact bonds (non-profits only)**
- **Partnerships, joint ventures, or affiliations with financially strong organizations**
Collaborative Models

- **Mergers and acquisition (M&A)** – These actions combine two or more organizations in a model where one organization owns the other(s), and gains all controls, rights, and liabilities.

- **Consolidations and "super parent" structures** – Unlike M&A, in a consolidation, all participating organizations lose their identities and emerge as a new organization. Participating organizations can spread the "overhead costs" for technology, financing expenses, compliance, marketing, legal counsel, and other core competencies over a larger revenue base. One method to accomplish this is to create a new parent organization (the "super parent") to control both organizations.

- **Joint operating agreements** – Joint operating agreements are a management agreement, typically between two organizations, that allows the organizations to share management services and some facilities, while retaining a separate board of directors. This is sometimes referred to as a virtual merger.
Collaborative Models (cont)

- **Shared services organizations (SSO) and administrative services organizations (ASO)** – This is similar in intent to the joint operating agreement, but with the creation of a separate organization to provide management services.

- **Purchasing cooperatives** – Purchasing cooperatives are focused on a single objective: reducing costs through "volume" purchasing discounts. These can be large, national agreements for purchasing, such as Purchasing Partners of America and Partners in Pharmacy Cooperative. Or the model can be smaller partnerships between two organizations who may join together to save on the purchase of technology or medical supplies.

- **Virtual service partnerships** – Virtual service partnerships are created between organizations to offer a specific service in the market (or respond to a specific RFP). The organization providing the service is "virtual." It is usually a trade name that operates in the market by organizations that are joined only by a partnership agreement. It is the partnership agreement that spells out proceeds, roles, and responsibilities and ownership of intellectual property.
Why Merge Or Acquire

Growth:
- Revenues
- Synergistic EBITDA
- Penetration

Risk Diversification:
- Payors
- Services
- Geography

Coordinated Care & Value-Based Payment Initiatives

Financial Roll-up: Private Equity

Survival:
- Health plan contracting
- NFPs – Cash Free Merger

Reallocate community funds

Burnout
Merger & Acquisition Options

Acquire or be acquired...

- Health plan
- Health system
- Provider organization – vertical positioning
- Provider organization – diversification positioning (service, geography, consumer, or payer)
- Provider organization – scale or market share