Moving to Risk and Value-Based Payment

A Governance Institute Webinar

presented by

Allen Miller
Principal & CEO

Andrew Snyder, M.D.
Principal & CMO
COPE Health Solutions

September 17, 2019

The Governance Institute® | A SERVICE OF nrc HEALTH

Today's Presenters

Allen Miller is the Principal and CEO of COPE Health Solutions. With over 25 years of experience providing health system and payer value based payment strategy and transformation consulting services, Mr. Miller has led the planning and implementation of IDNs, IPAs, and ACOs throughout the U.S. More recently, Allen has been focused on facilitating and implementing long-term payer/provider partnerships that go beyond the typical capitation and global risk models. These innovative collaborations are focused on reducing total cost of care and improving the total premium and other revenue needed to fund profitability and ongoing infrastructure investment. Under Mr. Miller's leadership, COPE Health Solutions and its subsidiary Analytics for Risk Contracting (ARC) LLC have become the preeminent go-to solutions companies for health systems and health plans committed to leadership roles in population health management for all lines of business.

Dr. Andrew Snyder is Principal and Chief Medical Officer with COPE Health Solutions with deep expertise in population health management, clinical integration, and alternative payment models. In 2015, Dr. Snyder joined the Mount Sinai Health System as EVP and Chief Clinical Integration Officer, where he worked to develop the clinical strategy for population health across the system, ensuring the physicians and the system exceled under health reform within alternative payment models. Dr. Snyder also previously served as President of Mount Sinai Health Partners IPA, with approximately 3,500 physicians across the network, both employed and voluntary. He also previously served as Senior Vice President and Chief Medical Officer of Brown & Toland Physicians IPA, where he oversaw all clinical programs including care management, quality improvement, and utilization management across all products and ACOs.

Learning Objectives & Continuing Education

After viewing this Webinar, participants will be able to:

- Assess your organization's readiness for upside only, two-sided, or global risk and the required capabilities to take on attributed/assigned populations.
- Pick partners and develop collaborative payer strategies (e.g., create a Medicare Advantage plan, direct to employer plan, grow business and improve performance together), including how to assess the current state of managed care contracts and what a value-based payment roadmap looks like.
- Explain the importance of ensuring the right enterprise-wide legal and operational structure is in place to align and manage clinical processes, care management, UR/UM, funds flow, and governance across different types of risk-bearing entities and payers.

Continuing Education Credits Available:

Jointly Accredited Provider: In support of improving patient care, The Governance Institute, a service of NRC Health, is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) to provide continuing education for the healthcare team. This activity was planned by and for the healthcare team, and learners will receive ***1 Interprofessional Continuing Education (IPCE)*** credit for learning and change.

IPCE CREDIT™

Continuing Education (continued)

The Governance Institute designates this live activity for a maximum of ***1 AMA PRA Category 1 Credit(s)™***. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

The Governance Institute is authorized to award ***1 hour of pre-approved ACHE Qualified Education credit*** for this program toward initial advancement, or recertification, of FACHE. Participants in this program who wish to have the continuing education hours applied toward ACHE Qualified Education Credit must self-report their participation. To self-report, participants should log into their MyACHE account and select ACHE Qualified Education Credit.

CPE: The Governance Institute is registered with the National Association of State Boards of Accountancy (NASBA) as a sponsor of continuing professional education on the National Registry of CPE Sponsors. State boards accountancy have final authority on the acceptance of individual courses for CPE credit. Complaints regarding registered sponsors may be submitted to the National
Registry of CPE Sponsors through its Web site: www. nasbaregistry.org.

Program level: Overview
No advanced preparation required
Field of Study: Business Management and Organization
Delivery method: Live Internet
Maximum potential CPE credits: 1.0

Criteria for successful completion: Webinar attendees must remain logged in for the entire duration of the program. They must complete the evaluation survey and include their name and degree (M.D., D.O., other) at the end of the survey in order to receive education credit. Evaluation survey link will be sent to all registrants in a follow-up email after airing of the Webinar.

Disclosure Policy

As a Jointly Accredited Provider, The Governance Institute's policy is to ensure balance, independence, objectivity, and scientific rigor in all of its educational activities. Presentations must give a balanced view of options. General names should be used to contribute to partiality. If trade name are used, several companies should be used rather than only that of a single company. All faculty, moderators, panelists, and staff participating in The Governance Institute conferences and Webinars are asked and expected to disclose to the audience any real or apparent conflict(s) of interest that may have a direct bearing on the subject matter of the continuing education activity. This pertains to relationships with pharmaceutical companies, biomedical device manufacturers, or other corporations whose products or services are related to the subject matter of the presentation topic. Significant financial interest or other relationships can include such thing as grants or research support, employee, consultant, major stockholder, member of the speaker's bureau, etc. The intent of this policy is not to prevent a speaker from making a presentation instead, it is The Governance Institute's intention to openly identify any potential conflict so that members of the audience may form his or her own judgements about the presentation with the full disclosure of the facts. It remains for the audience to determine whether the presenters outside interests may reflect a possible bias in either the exposition or the conclusion presented. In addition, speakers must make a meaningful disclosure to the audience of their discussions of off-label or investigational uses of drugs or devices.

All faculty, moderators, panelists, staff, and all others with control over the educational content of this Webinar have signed disclosure forms. The planning committee members have no conflicts of interests or relevant financial relationships to declare relevant to this activity. *The presenters have no financial relationship with The Governance Institute or NRC Health.*

This educational activity does not include any content that relates to the products and/or services of a commercial interest that would create a conflict of interest. There is no commercial support or sponsorship of this conference.

None of the presenters intend to discuss off-label uses of drugs, mechanical devices, biologics, or diagnostics not approved by the FDA for use in the United States.

Agenda

- Drivers of Change
- Value-Based Payment (VBP) Contracting Overview
- Readiness and Infrastructure Requirements for Success
- Successful Payer Collaboration Strategies

Presentation Overview

- As more and more health systems, hospitals and medical groups feel the financial and competitive impetus to transition to risk and value-based payments, it is critical for boards to understand their organization's readiness to scale and succeed in value-based contracts with greater premium risk.

- In this session, we review common legal operational structures required to manage risk and funds flow, how to identify the right payers or new market entrants with whom to partner in a risk-based strategy, how to grow and optimize your network to ensure success throughout your contracts (risk-based and fee-for-service), and how to stay market competitive.

Drivers of Change

Polling Question #1

How much of your hospital or health system revenue today is earned through value-based payment agreements with at least upside shared savings opportunity?

- <10%
- 11-25%
- 26-50%
- 51-75%
- 76-100%
- Unknown

Current Drivers of Healthcare Transformation

Current Administration

- Value-Based Purchasing Programs accelerate competition for the fixed premium dollar.
- Data-driven, patient care strategy drives demand for greater transparency and strategies that address interpretation of cost, quality, and outcome data on impact of business.
- "Patients Over Paperwork" and the shift from "middle man entity" in managed care drives need to engage and build consumer-directed healthcare and accountability models.
- Focus on pharmaceutical management, transparency and pricing, and opioid epidemic in target populations.

Impact of the End of the Sustainable Growth Rate, MACRA 2015

- Quality Payment Program's (QPP) consolidation of pay-for-performance models with MIPS.
- Increased impact to Medicare reimbursement with penalties and bonuses, levels of provider participation and four categories of reporting requirements that require need for interoperability.
- MIPS requires strategy to assess and identify measures, engage and motivate providers to improve metrics, map data sources in EHR, train staff and develop workflows to sustain success.

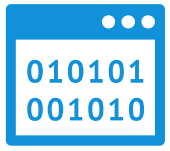
Risk-Based Contracting

- New CMS and direct to employer opportunities, coupled with state drives toward VBP contracting, make for exciting opportunities and higher stakes with relation to the decision for providers and provider-owned risk-bearing entities to take more risk.
- Payers, from CMS and employers to health plans, are looking for competent providers who can take risk and delegation – *it is a key aspect of the JP Morgan, Buffet, Amazon collaboration.*

Medicaid Redesign and Expansion

- Cost containment, consumer accountability and work requirements, administrative simplification and more state control – providers are being positioned to take risk and manage population health.
- Integrating care remains key and now includes models for maternal and child health populations.

Convergence of Payments and Care

Issue	Implication
 **Managed Care Transition**	• Managed Medicare and Medicaid continue to be main growth areas, with direct-to-employer catching on, even in markets in which ASO relationships have been blockers. • Less fee-for-service and more risk/capitation – ACOs and Advanced BPCI are just gateways to managed care/capitation. • Providers, particularly hospitals, still have "one foot in each canoe," with respect to revenue and EBITDA, between fee-for-service and value-based payments.
 **Care Delivery Integration**	• Increasingly rapid migration of care from traditional locations to home and community care, sparked by financial incentives and penalties. • Home and community monitoring, direct to member communication and management, telehealth all growing rapidly. • Continued provider and payer consolidations with more integrative relationships.
 **Role of Data**	• Today: increasing demand for data-driven decisions and metrics to measure value and drive revenue; providers learning to use claims as well as encounter and clinical data. • Tomorrow: how will DNA data be analyzed and used? Finger prick with phone adapter transmits DNA results to pharma/physician who then send you personalized medicines by drone? DNA-based "chase lists?"

Value-Based Payment Contracting Overview

Polling Question #2

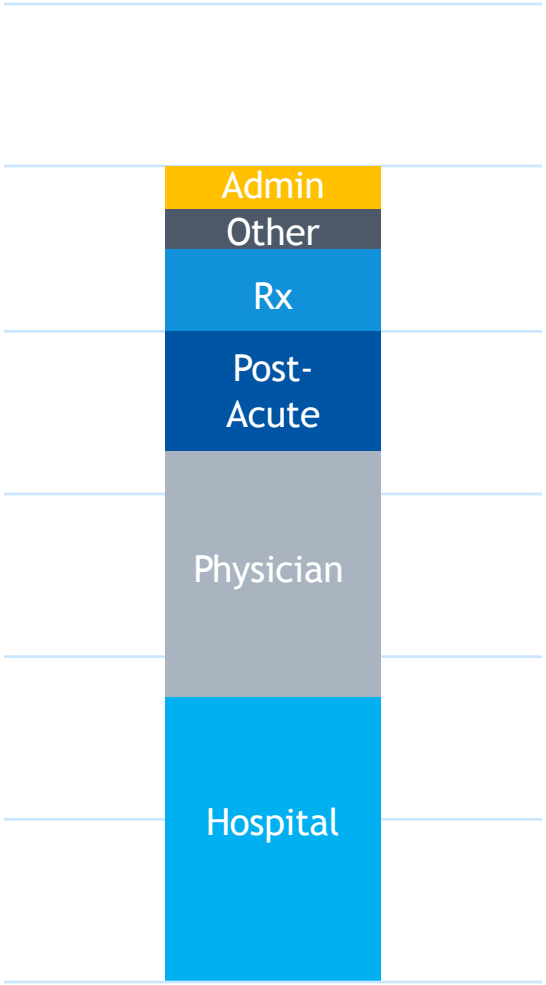
Is your hospital or health system taking downside risk through any agreements today?

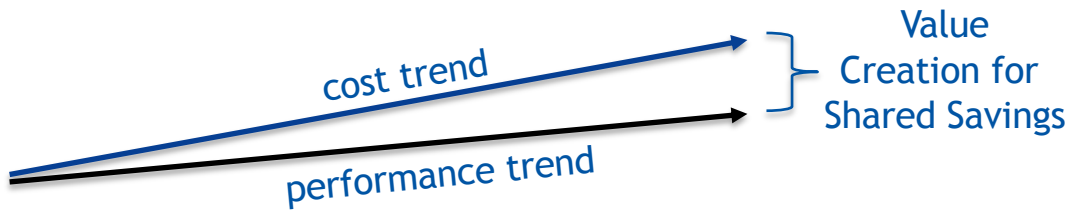
- Yes
- No

If yes, for how many covered lives?

- <10k
- <50k
- <100k
- >100k

Basic Value-Based Payment Contracting Construct





Contract

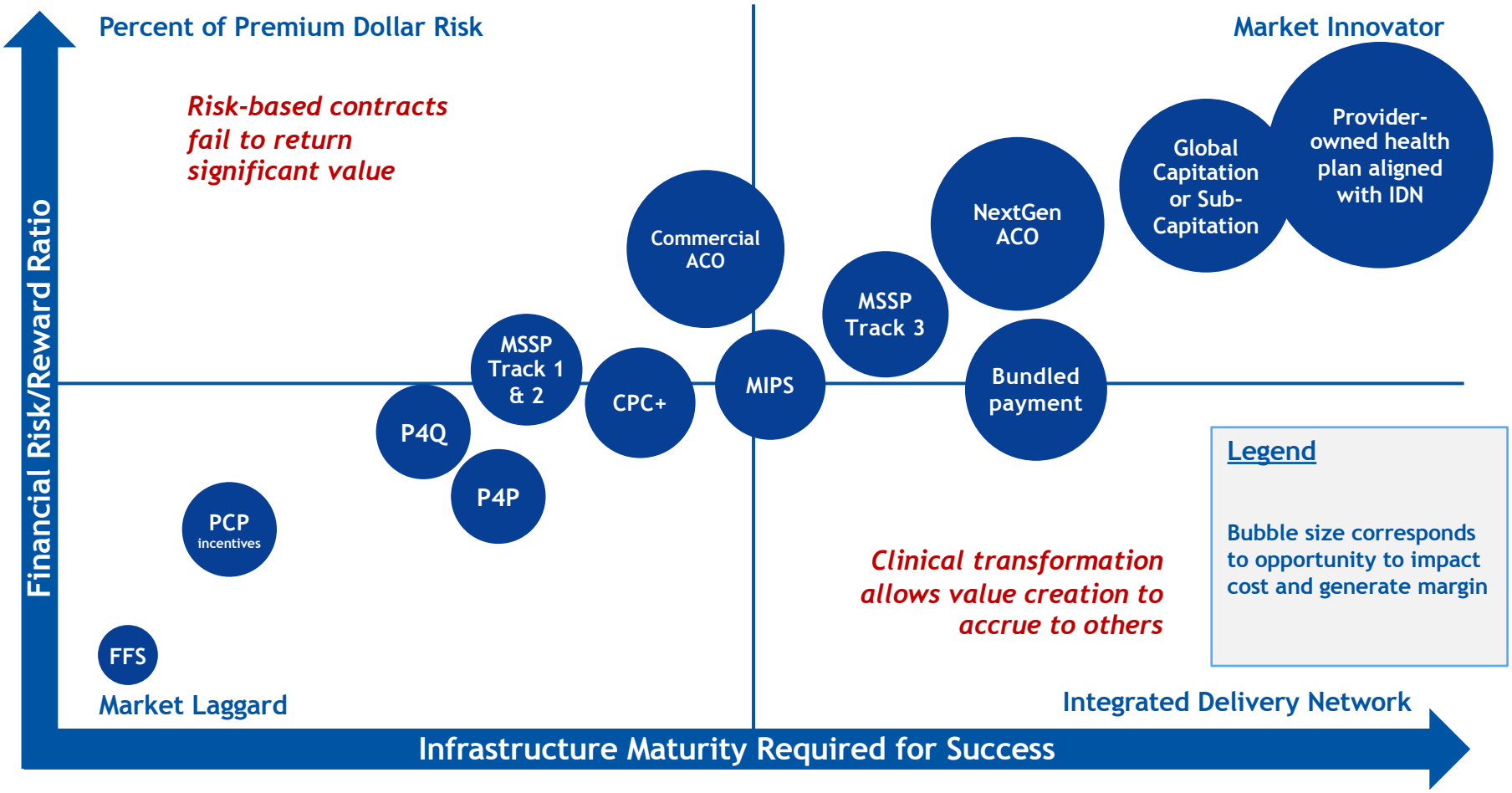
- Patients assigned based on primary care physician
- Basic contract structure is to provide incentives for reducing total cost of care
- Common components:
  - Level value-share and risk
  - Minimum savings/loss rates
  - Prepayment of value-share
  - Quality-based incentives

Value Creation

- Gaining more risk-adjusted membership
- Reduce utilization of outside spend (post-acute, Rx drug, medical devices)
- Manage referrals and reduce leaks
- Reduce internal spend (hospital utilization, unnecessary specialist visits) while removing capacity
- Improve efficiency of underlying costs

The VBP Spectrum

Value-Based Reimbursement Continuum



Understanding Medical Loss Ratio (MLR)

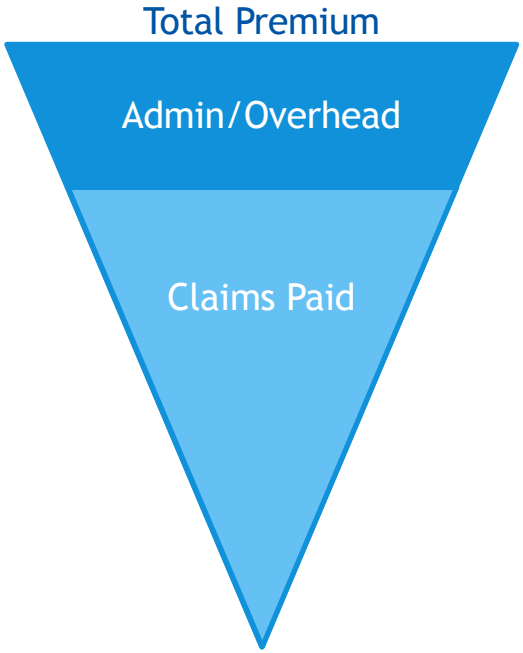
What Is Spent on Medical Care?

Capitated organizations must understand cost drivers and track, analyze, and communicate utilization information in order to effectively manage total cost of care.

Medical Loss Ratio (MLR) is the ratio of total medical claims over the premium using the following formula:

$$Medical\ Loss\ Ratio\ (MLR) = \frac{Spend\ on\ Medical\ Care}{Premiums}$$

Administrative Loss Ratio (ALR) is the remaining overhead that is being spent on administrative overhead.



Understanding the MLR enables risk-bearing entities to:

- Budget and negotiate better risk contracts for appropriate fee structures and bonus incentive mechanisms
- Manage risk pools and inform strategies to enhance the profitability of the pools
- Understand the financial impact and scenarios under which to subcontract with providers

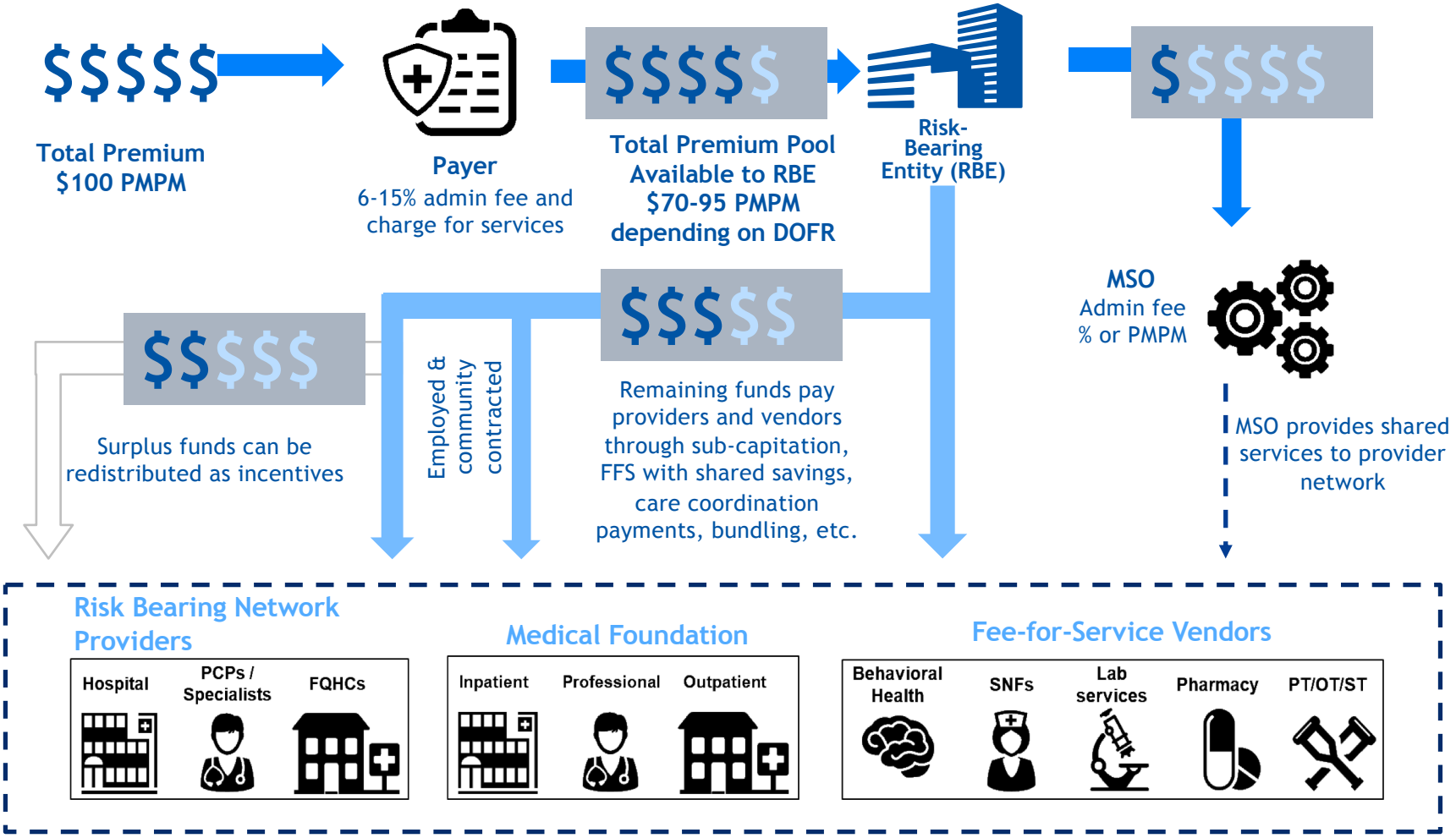
Division of Financial Responsibility (DOFR)

A DOFR is a part of the contract between two or more partners (ex: payors, providers, IPAs, MSOs, medical foundations) that outlines who pays for which health services under a risk arrangement.

- The DOFR delineates which stakeholder is responsible for specific medical expenses such as pharmacy, professional, inpatient, outpatient, etc.
- Financial responsibility is generally delegated to the partner best positioned to:
  - Manage populations and reduce utilization
  - Leverage best practices/expertise/align provider network
- Costs are allocated to the partners in the risk arrangement, including:
  - Health plan, IPA/medical group, hospital, carve-out benefit providers

SERVICES	IPA MEDICAL GROUP	HEALTH PLAN
PREVENTIVE SERVICES		
1. Health Education/Promotion	*X*	*X*
Immunizations/Serum:		
– *Adult Immunizations*		*X*
– *Childhood Immunizations first recommended for use by the American Academy of Pediatrics on or after 1/1/01 and Prevnar*		*X*
– *Other Childhood Immunizations*	*X*	
2. Routine Physical Exams	*X*	
3. Vision/Hearing Screenings	*X*	

Global Premium Risk Model Example



Readiness and Infrastructure Requirements for Success

Keys to Success in Risk-Based Environments

Quality Management

Approaches to effectively manage overall total cost of care through appropriate medical use

Examples:

- STAR ratings
- HEDIS gap closure
- Member engagement
- Provider & staff engagement
- Ease of use of quality identification & action tools

Revenue Optimization

Strategies to increase total revenue and increase the risk sharing the provider can manage

Examples:

- Appropriate product category
- Appropriate risk coding
- Contracting strategy
- Financial reconciliation for claims & eligibility

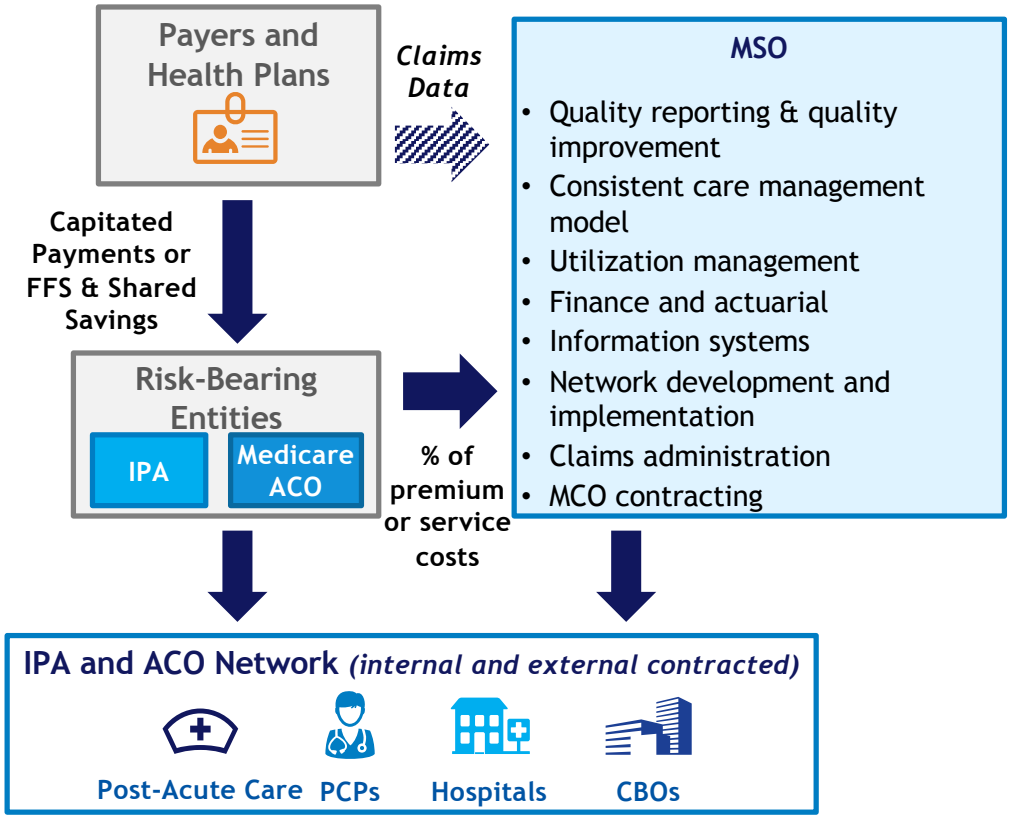
Clinical Efficiency

Alignment of provider operational strategies with risk strategies to maximize care delivery value

Examples:

- Appropriate site, level of care, proactive UR, aligned incentives
- Ease of access & leakage reduction
- Identify & address SDH, CBO integration
- Rx dispensing channel
- High volume/high-risk member management

Risk-Bearing Entities Overview



Management Services Organization (MSO)

- Provides services to help improve quality and cost; introduces real opportunity to improve utilization – aligns with clinical restructuring
- Promotes financial discipline and sustainability by charging a portion of premium dollar for all risk contracted MCOs
- Standardizes care management model across continuum
  - Leverage scale on a per member, per month (PMPM) basis

Independent Practice Association (IPA) or Accountable Care Organization (ACO) and/or Clinically Integrated Network (CIN)

- Large group of physicians who perform services for patients
- Transforms physician behavior through alignment of incentives across multiple MCOs
- Member providers are affected by risk – they will earn or lose money according to quality and cost of care delivered

Polling Question #3

Are you delegated for care management or any other MSO/population health management services through your VBP arrangements?

- Yes
- No

If so, for which of the following are you delegated?

- Care management
- UR/UM
- Credentialing
- Network management
- Claims

Polling Question #4

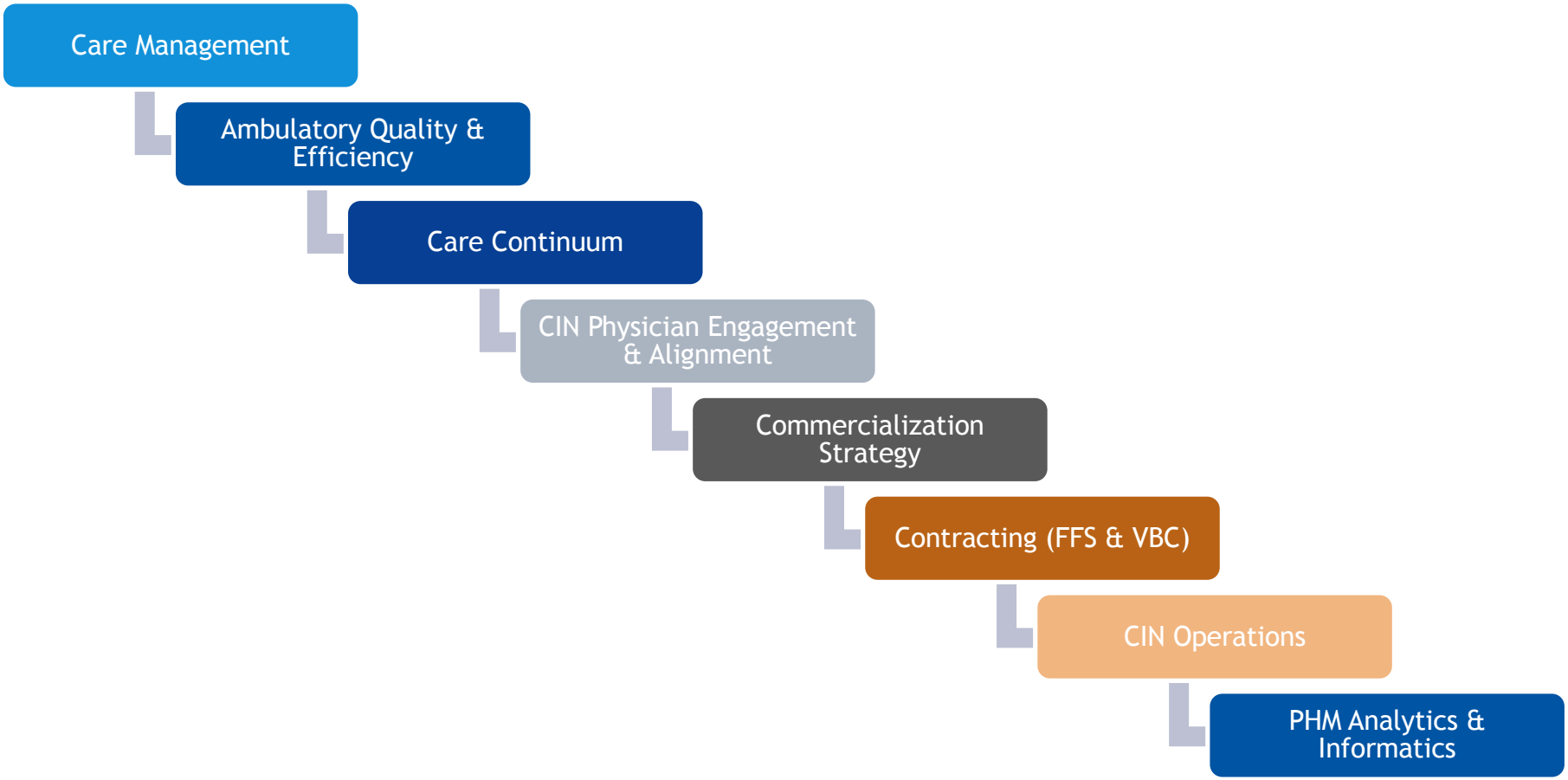
Do you take risk with any independent physician associations or accountable care organizations for any line of business with one or more payer partners (besides CMS MSSP programs)?

- Yes
- No

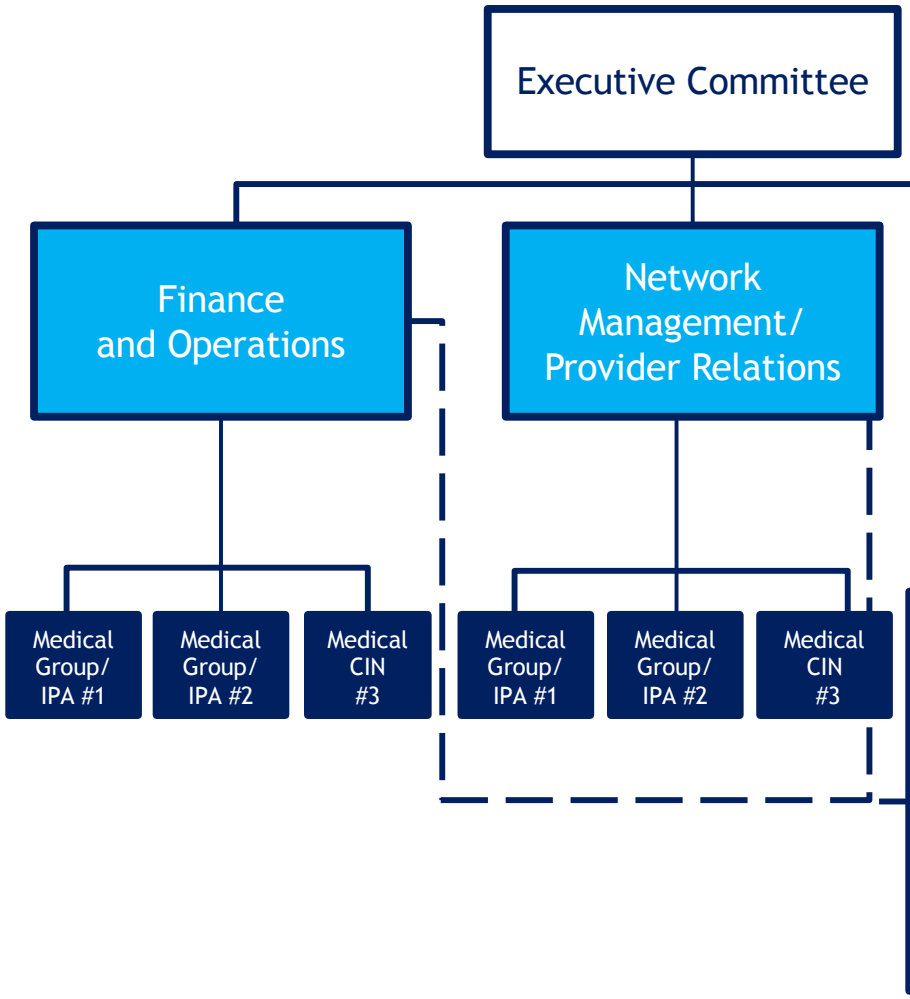
A Shift in Focus: Measuring Performance

	Fee-for-Service Metrics	Transition Phase Metrics	Global Capitation Metrics
Outpatient	Charge volume	Disease management indicators (A1C control, BMI)	Risk-adjusted attribution
	Charge lag	Care management quality metrics (outbound calls, ED diversion rate)	PMPM & utilizations per thousand
	A/R days	Availability of PCP appointments per 24-period	Primary care connectivity, wellness visits
	Visit volume & throughput	In-network urgent care utilization rate	Attributed member retention rates
	Denial rate	Patient inquiry response rate (e.g., nurse line, patient portal responses)	Provider satisfaction with referral process and specialist availability
	Physician productivity (RVUs)	Preventive health indicators (e.g., immunization rate)	Referral management & high-value network
Inpatient	ALOS	Total cost for the episode (bundle)	Comprehensive patient experience (HCAHPS)
	Average daily census	Avoidable hospital readmission rate	Utilization management
	Contribution margin/case type (linked to case mix index)	Total FFS cost of care for defined population (PMPY FFS claims)	Leakage management & repatriation
	Charge volume	Patient safety (UTI, central line infection, surgical site infection)	IP readmission rates, SNF days per 1000
	Time to discharge	Potentially avoidable ED visit rate	ER visits per 1000
	Accurate ICD-9/10 coding compliance rate	PMPM	Quality scores including STARS and accurate ICD-9/10 coding compliance rate

Population Health Interdependent Functions



Example: Governance Structure



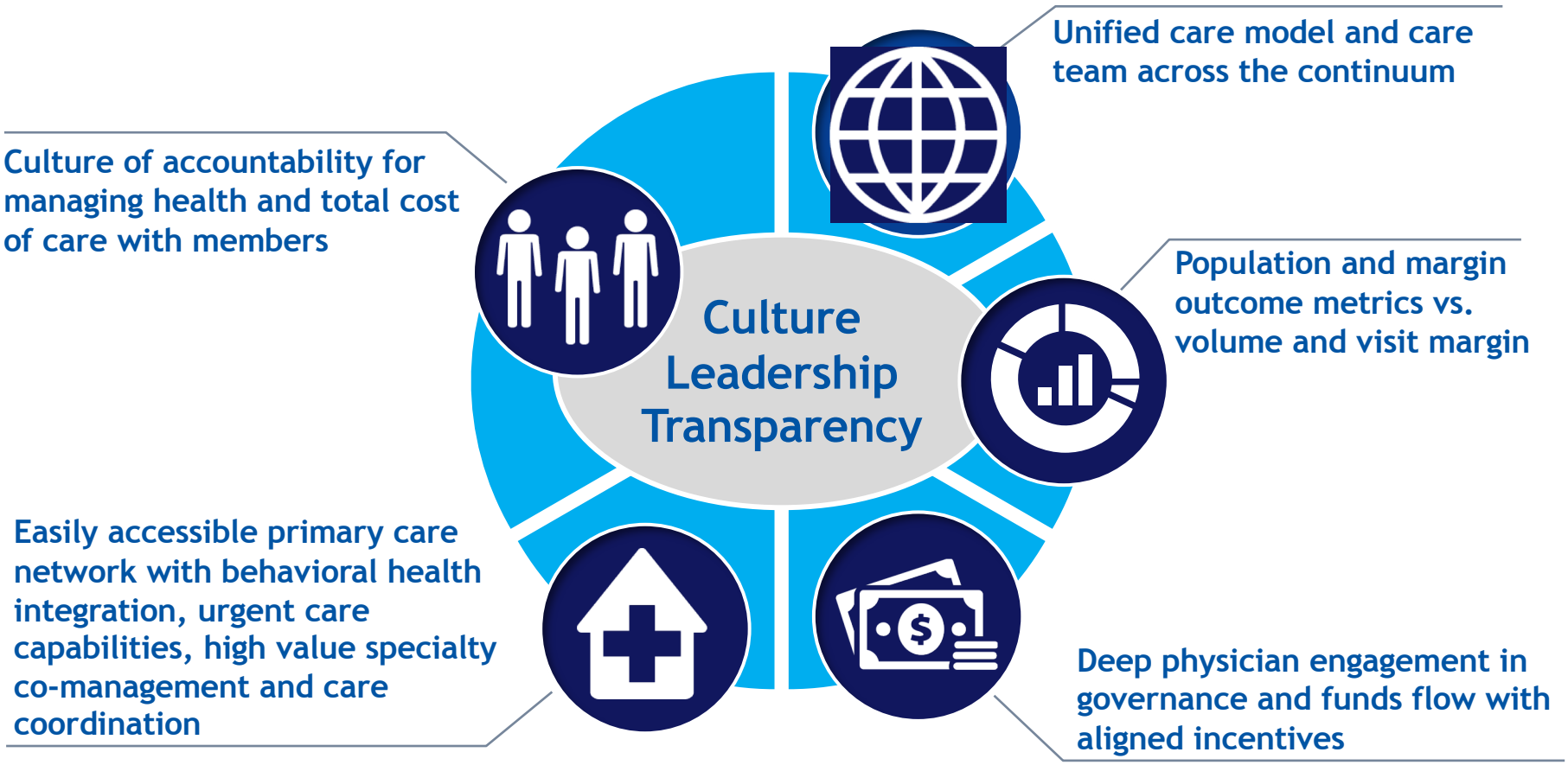
- Oversight of performance and success
- Evaluates and informs strategic and operational priorities
- Delegates development of initiatives and implementation requirements/planning to the sub-committees
- Receives recommendations and updates from committee co-chairs

- Oversight for execution of strategy and fulfillment of objectives set by executive committee
- Establishes standards, operational processes, and solutions
- Receives recommendations and updates from medical group leadership

- Oversight for implementation and adoption of standards established by executive and other committees
- Adapts standards and guidelines to medical group, hospital, and respective network workflows as appropriate
- Provides recommendations and updates to committees (including executive) with relation to management and priority issues
- Leads respective physician engagement and feedback loops

VBP Critical Success Factors

Fundamental design principles for downside or global risk:

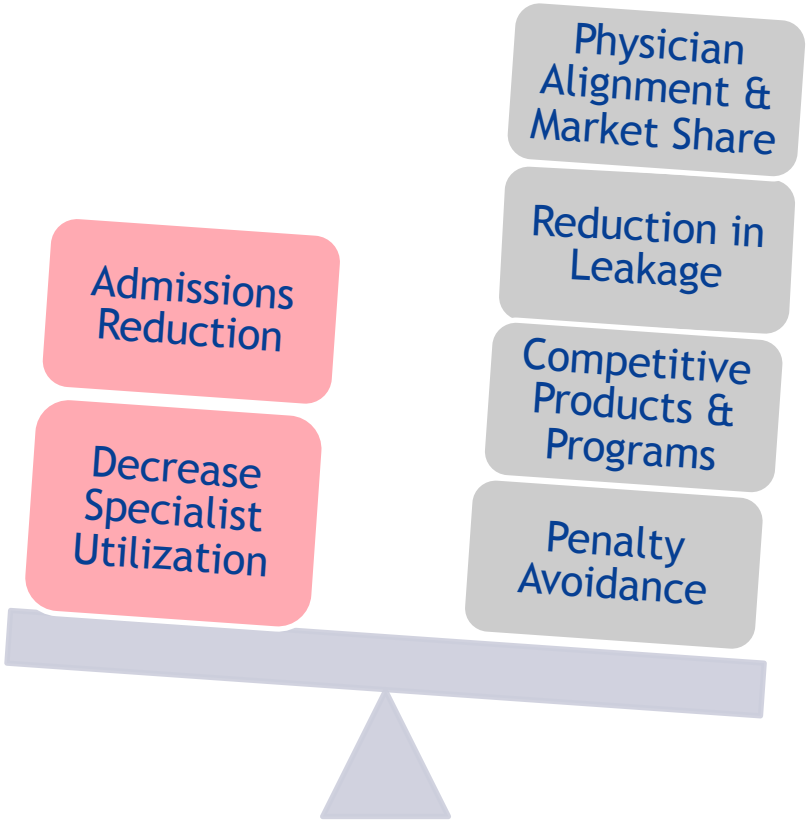


Successful Payer Collaboration Strategies

Key Considerations

- Do you have one or more true payer partners today?
- Are you looking for payer partners?
  - If so do you feel the need to look outside your market?
- What do you expect to achieve through the partnership?
  - Greater market share to drive acute utilization
  - Enhanced profitability on book of business
  - Partner to better manage a population for total cost of care
  - Delegation and funding of MSO services at the health system/risk bearing organization level in order to fund development of those capabilities
  - Other

System Puts and Takes



A robust P&L forecast of the system through the transformation would support future decision-making around population health investments

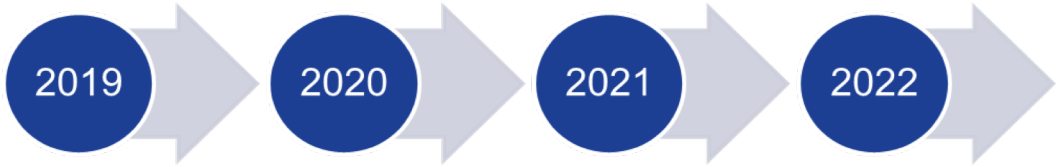
Most Challenging Issues to Manage under Health System VBP Arrangements

- EMERGENCY DEPARTMENT UTILIZATION
- BEHAVIORAL HEALTH
- OUT OF NETWORK UTILIZATION
- COSTLY OUTLIER CASES
- CHRONIC ILLNESSES
- SAFE-DISCHARGE ISSUES DECREASE CAPACITY
- DENIALS AND CUTS
- SDOH IMPACT ON PATIENT-CENTERED CARE

These are factors on which payers can be better partners

Value Based Payment Roadmap Considerations

Topics for Consideration:
Risk Based Entity / Vehicle IPA, ACO, Restricted Knox Keene Regulatory requirements met
Value Proposition(s) Payers, attributed or assigned members, and physicians and other key network providers
Network Development Provider contracting, membership, membership criteria, growth
Governance and Leadership Governance make-up, committee make-up, committee charters, leadership positions
Infrastructure Development MSO development, population health IT (PHIT), care management
Payer Partnerships Self-insured employers and payers
Financing Shared savings, funds flow, budgeting



The Move to Value Is All About Risk Transfer

Six key questions:

1. Do you have a network and alignment vehicle that can work beyond an individualistic construct?
2. Do you have the position, experience, data, and resources to negotiate favorable contracts?
3. Do you have a very good care management solution? (not just a check box)
4. Do you have the capacity to get NCQA certified delegation for UM and CM?
5. Do you have very strong financial reporting and modeling?
6. Do you have all the data and can you manage, analyze, and report it to drive performance both internally and externally?

Strategic Partnerships: Pick the Right Partners

What makes a good payer partner?

1. Do they have membership in your target geographies or a plan to grow membership with you?
2. Are they already closely aligned with competitor risk bearing entities?
3. Do they have experience with value-based payment contracting, and are they willing to both give adequate access to the premium and delegate MSO services you want to control?
4. Have they developed, or are they committed and underway to developing, population health management capabilities that they can deploy consistently that would add value for you?
5. Are they committed to delegating down to your health system or risk based organization those population health management services you want to build?
6. Can they help you with care coordination processes with behavioral health and other CBOs to address SDOH?

Questions & Discussion

Contact Us…

Allen Miller
Principal and CEO
COPE Health Solutions
(310) 386-5812
amiller@copehealthsolutions.com

Andrew Snyder, M.D.
Principal and Chief Medical Officer
COPE Health Solutions
(401) 225-9417
asnyder@copehealthsolutions.com

The Governance Institute
9685 Via Excelencia, Suite 100
San Diego, CA 92126
Toll Free (877) 712-8778
Info@GovernanceInstitute.com

COPE Health Solutions Locations

Los Angeles Office
1150 S Olive Street
Suite 1200
Los Angeles, CA 90015
(213) 259-0245 Office

New York Office
505 5th Ave
11th Floor
New York, NY 10017
(646) 768-0006 Office