OREGON HEALTH AUTHORITY'S TRANSFORMATION CENTER

SPRING 2021: VALUE-BASED PAYMENT WEBINAR SERIES

Session #2: What providers need to know when negotiating value-based payments

APRIL 21, 2021

W W W . H E A L T H M A N A G E M E N T . C O M

WEBINAR SERIES OVERVIEW

- This is the second of a 5-part series focused on Value-Based Payment (VBP) for Providers
- The objectives of this series include:
  - Provide an overview of VBP models as they apply to the Oregon landscape
  - How VBP can support providers to improve patient outcomes through more comprehensive and flexible approaches to delivering healthcare services
  - Enhance primary care, behavioral health and maternity care providers' readiness for VBP adoption
- Sponsored by the Oregon Health Authority's Transformation Center in collaboration with Health Management Associates
- 1.0 hour of CME is available through the American Academy of Family Practice, equivalent to AMA PRA Category 1 Credit™ toward the AMA Physician's Recognition Award. To receive the credit, you must complete the evaluation following the session

2021 Webinar Series, 12 – 1pm on:

- **March 17 (Recording available)**
- **April 21**
- **May 19**
- **June 2**
- **June 16**

SPEAKERS AND DISCLOSURES

Faculty	Nature of Commercial Interest
 **Jeanene Smith MD, MPH** **Presenter and Curriculum Adviser**	Dr. Smith discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of healthcare clients. As a member of the American Academy of Family Practice (AAFP), she ensured the content met the AAFP CME requirements.
 **Janet Meyer** **Presenter**	Ms. Meyer discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of healthcare clients.
 **Art Jones MD** **Presenter**	Dr. Jones discloses that he is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of healthcare clients. He is also employed as Chief Medical Officer of Medical Home Network, a non-profit that supports Medical Home Network ACO and other safety net clinically integrated networks to transform care are under advanced alternative payment models.

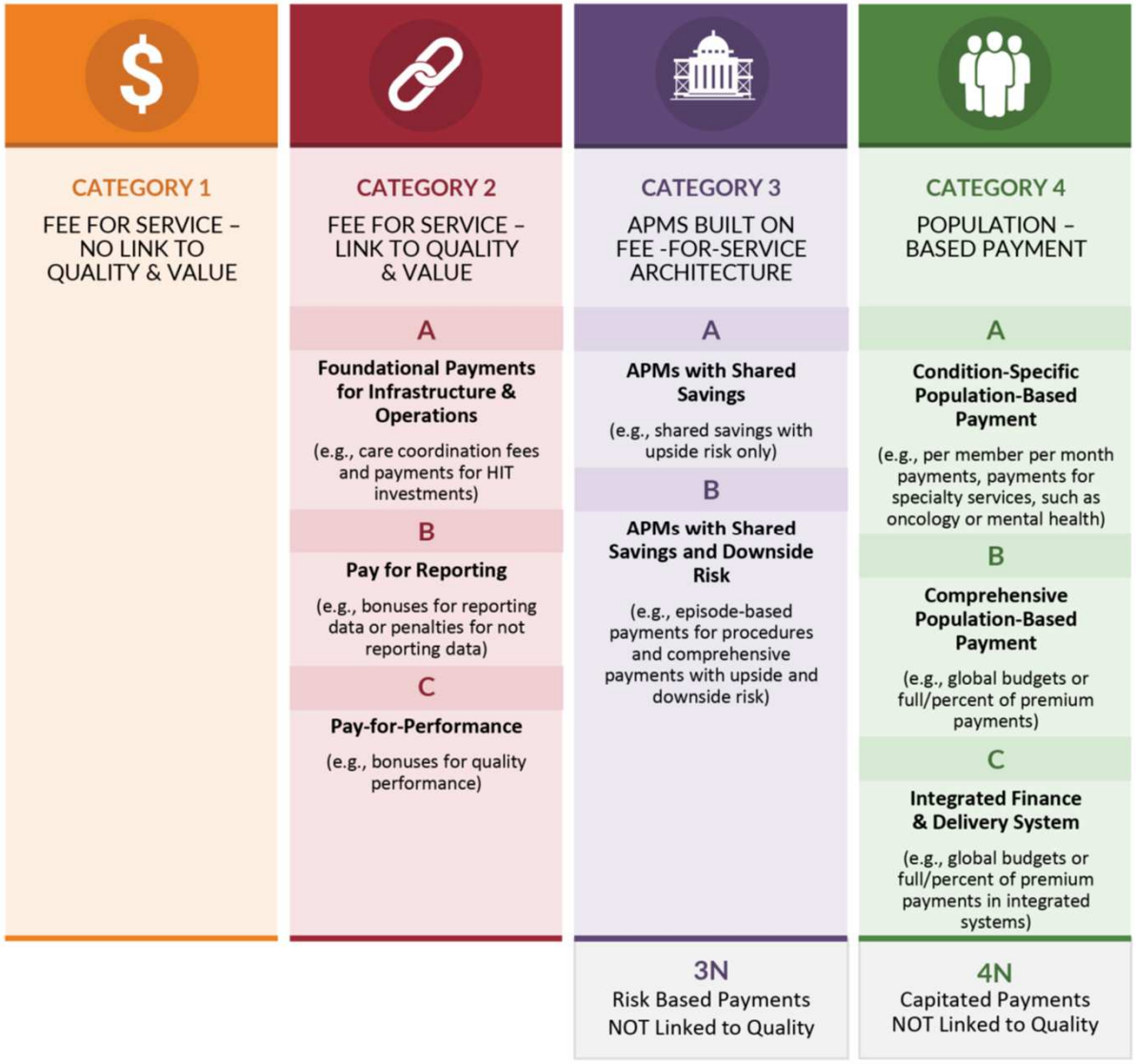
TODAY'S AGENDA & LEARNING OBJECTIVES

- Welcome and Introductions
- Brief overview of value-based payment models and associated Health Care Payment Learning & Action Network (HCPLAN, or LAN) categories
- Overview of Oregon's CCO VBP requirements
- Discussion of key contract terms for value-based payment models and their impacts on workflows and practice models
- Analytical resources and tracking outcomes
- Q & A

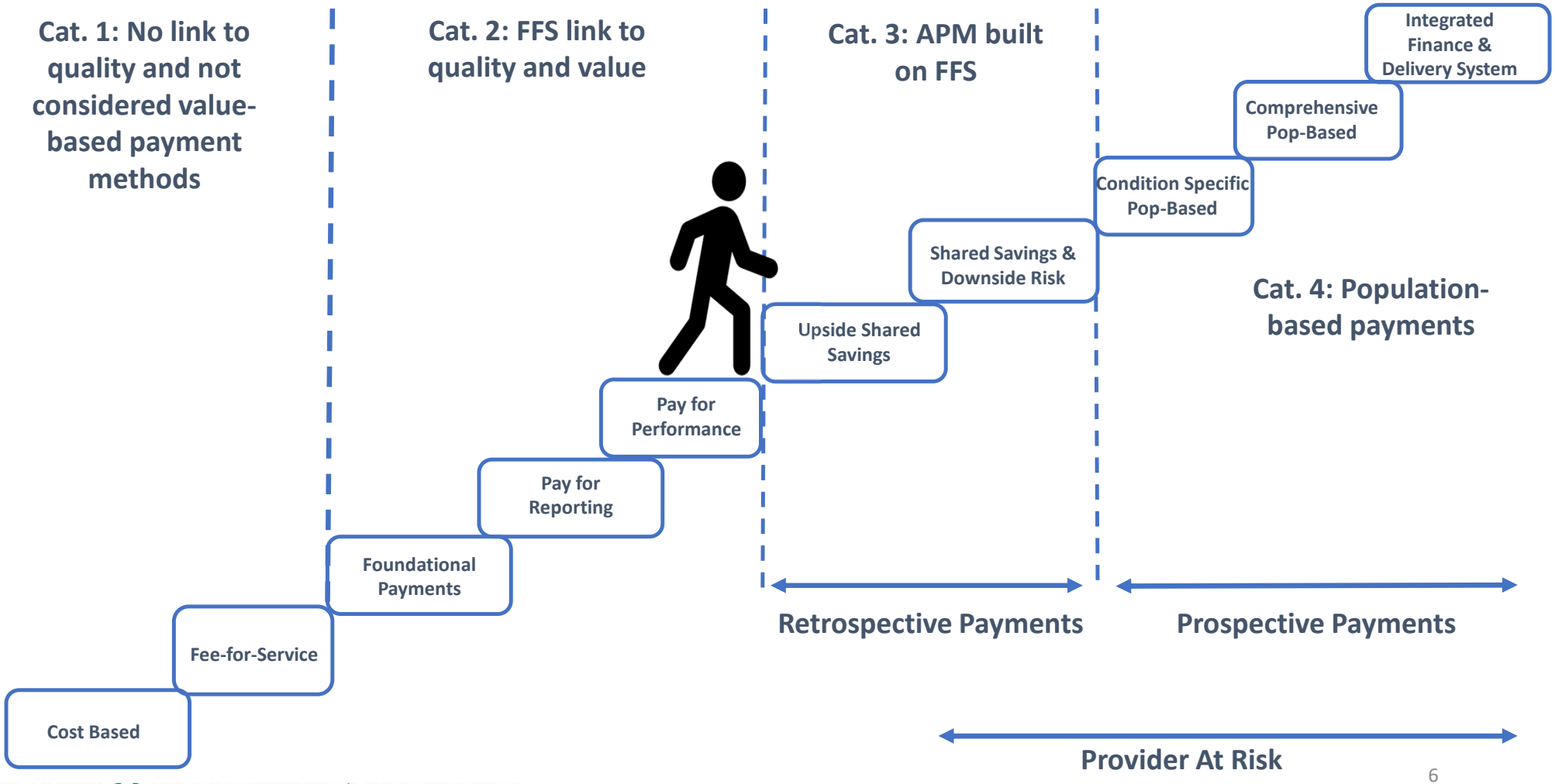
After this webinar, participants will be able to:

- List which types of VBP models fall into the four Health Care Payment Learning & Action Network (HCPLAN, or LAN) categories
- Evaluate proposed VBP contract terms and formulate counter proposals that will better facilitate successful transition to outcomes-based incentives to meet the needs of your practice.
- List 2-3 key things to ask from payers beyond payment terms
- Identify metrics and performance targets that should be regularly tracked to gauge success, prompt further modification to practice patterns and inform the next negotiation

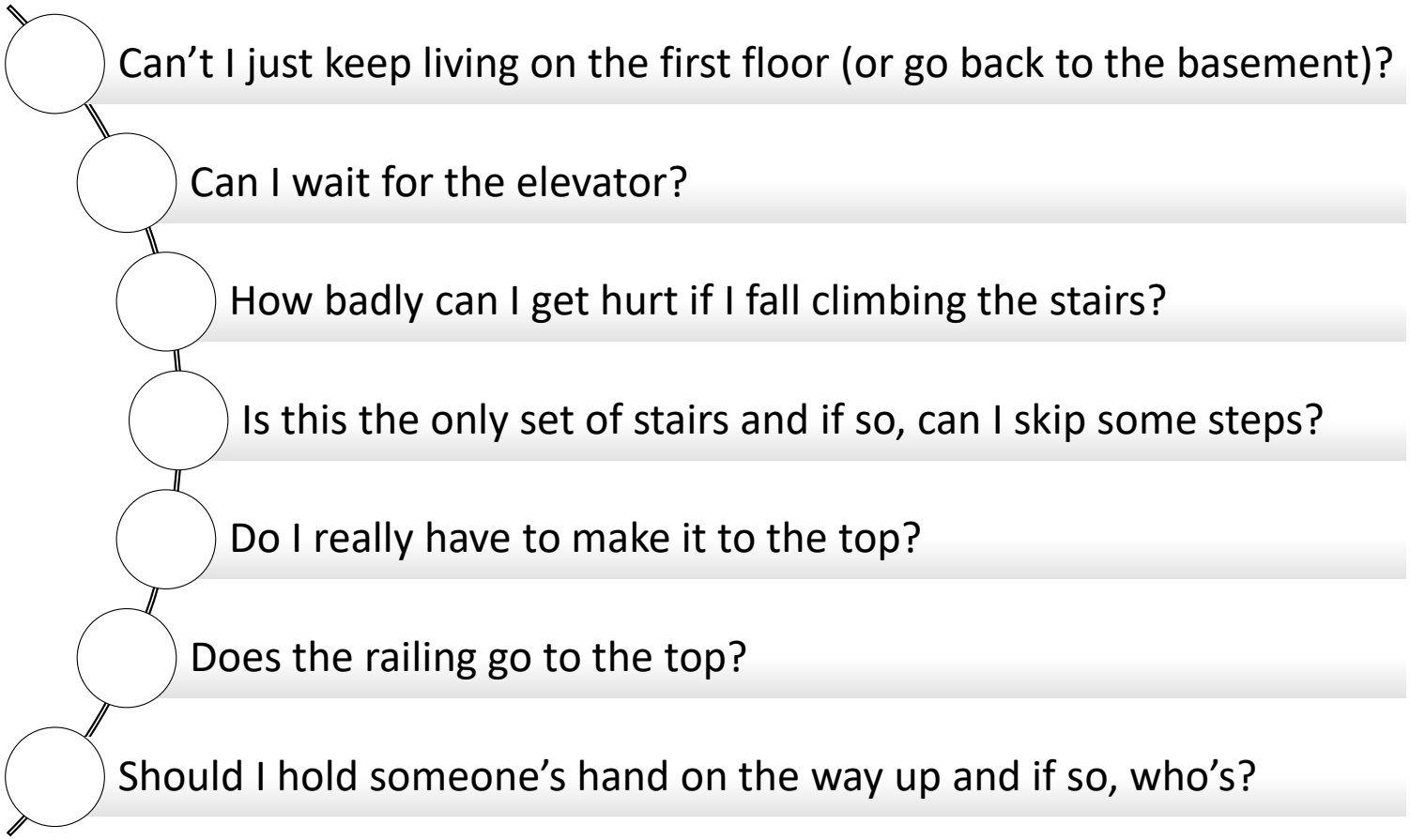
VALUE-BASED PAYMENT FRAMEWORK FROM THE HCP - LAN



PROGRESS IN PURSUIT OF VALUE-BASED PAYMENT: LAN VBP CATEGORIES



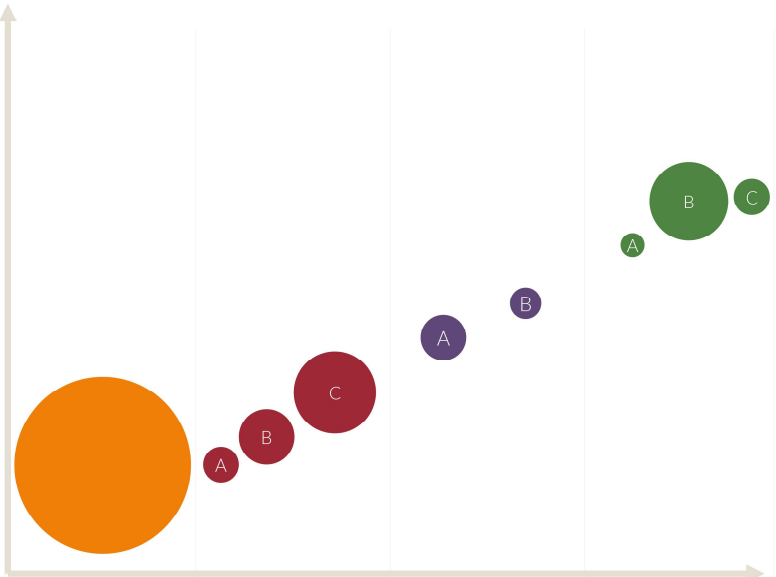
QUESTIONS PROVIDERS ARE ASKING ABOUT LAN CATEGORIES AND THEIR PROGRESSION



HCP - LAN PAYMENT REFORM GOALS

- Provider accountability and innovation
- Impact of payments on cost and quality performance
- Delivery system integration and coordination
- Person-centered care

Current State



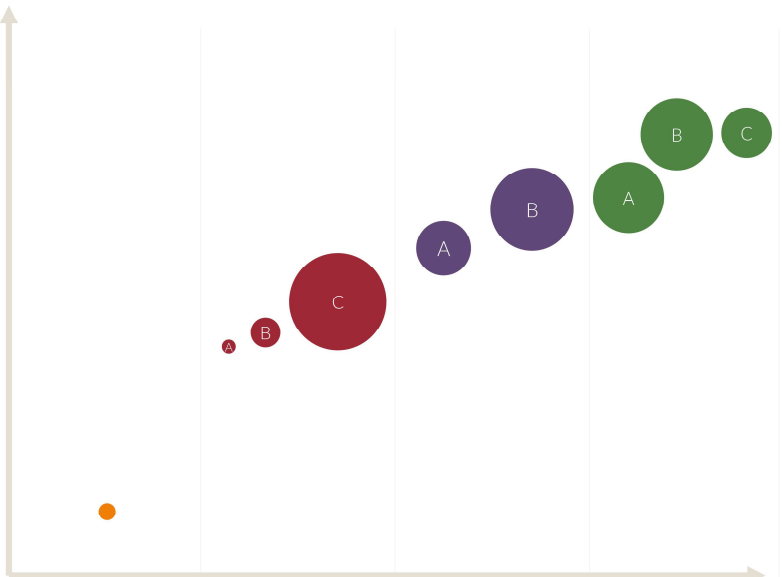
Category 1
Fee for Service
-
No Link to Quality & Value

Category 2
Fee for Service
-
Link to Quality & Value

Category 3
APMs Built on Fee-for-Service Architecture

Category 4
Population-Based Payment

Future State



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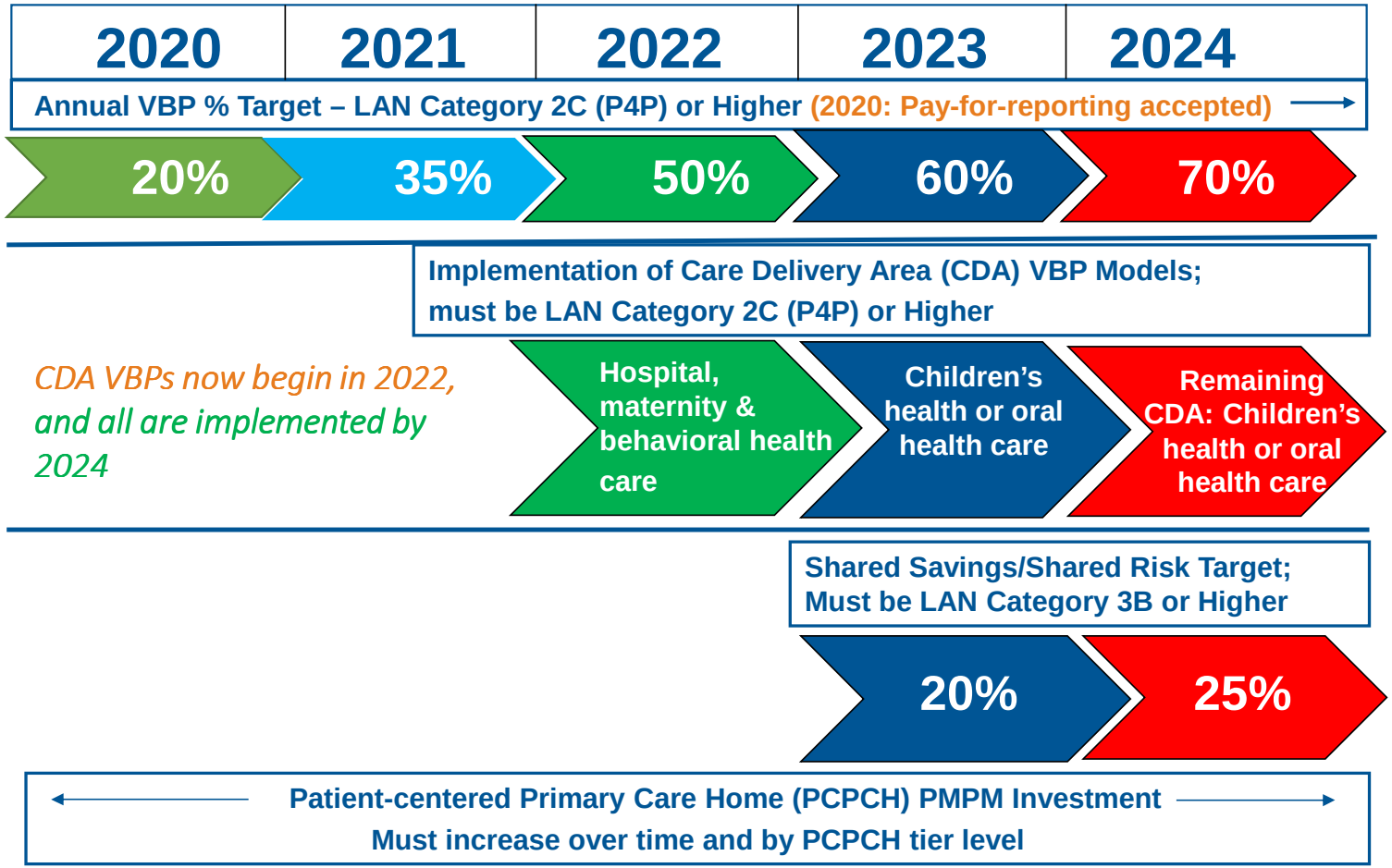
OREGON'S MULTI-PAYER VBP MINIMUM TARGETS

CCOs manage the care for more than a million Oregon Health Plan enrollees. Part of their contract with the Oregon Health Authority includes minimum VBP payments as a percent of total payments to providers each year.

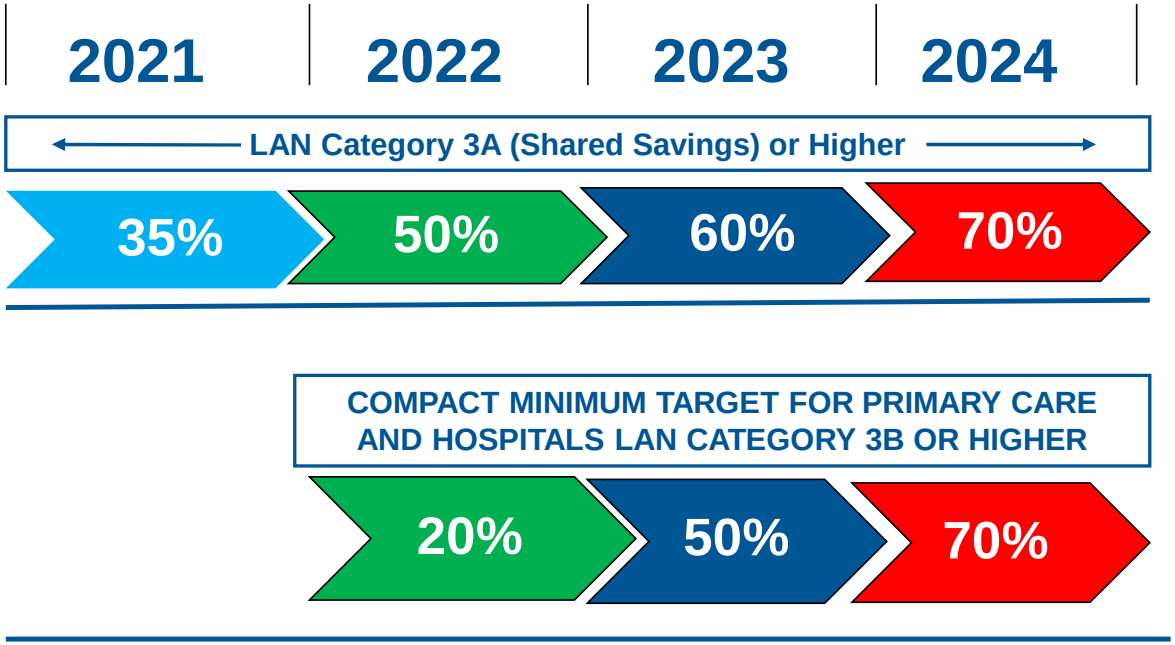
The **VBP Compact** is a statewide collaborative partnership to increase the spread of VBP models across the state as a strategy to improve quality and lower costs. Payers, providers, and other stakeholders across the state have made a voluntary commitment to participate in and spread VBPs.

CCO 2.0 VBP REQUIREMENTS



Timeline Reflects COVID-19 Revisions

OREGON'S VBP MULTI-PAYER COMPACT



VBP CONTRACTING – PROACTIVELY NEGOTIATING TERMS

Key elements that should be incorporated into value-based payment contracts between a provider and a payer include:

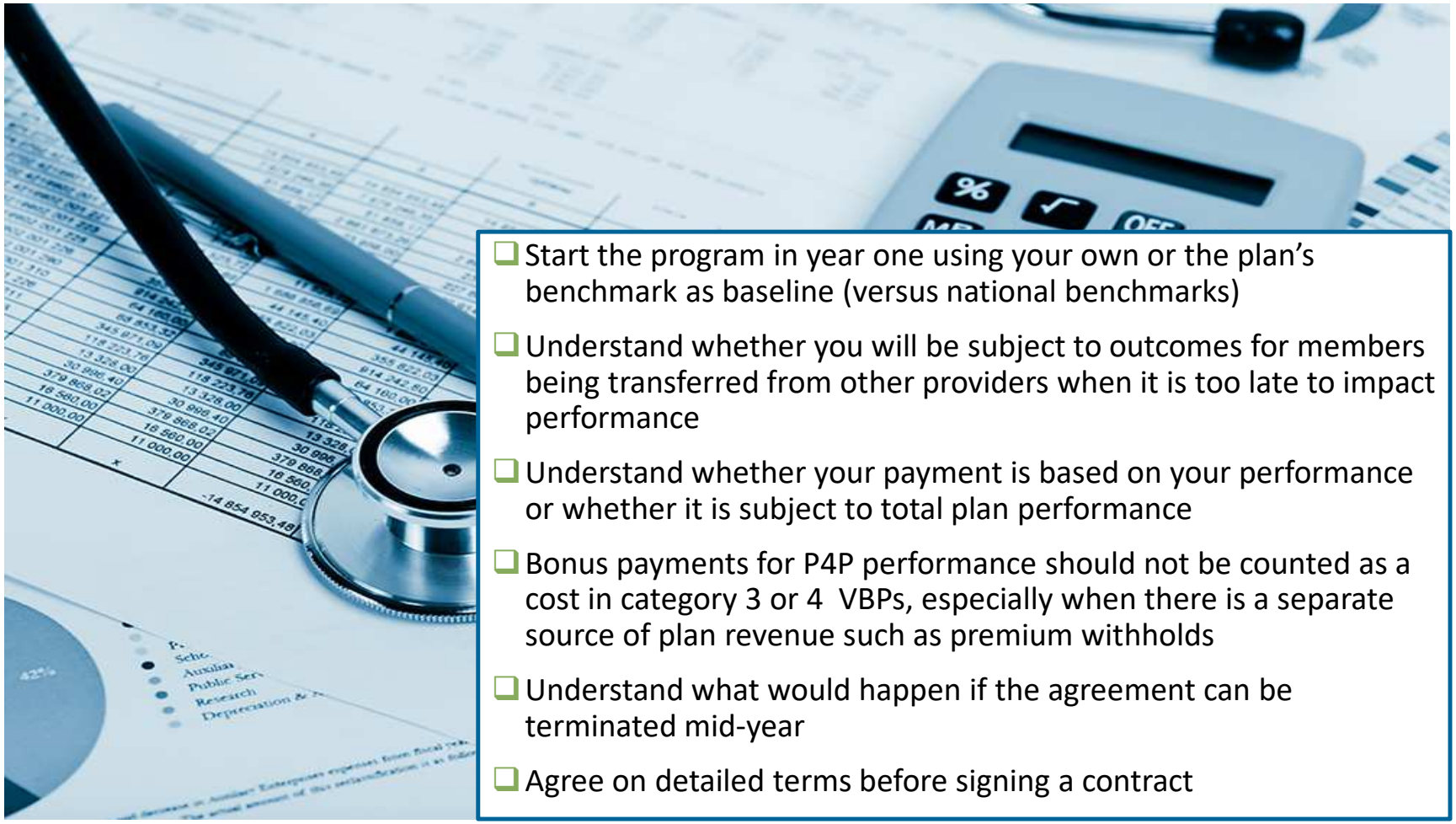
- Specificity regarding the included populations and covered services
- Patient attribution/member assignment
- Information exchange including data and reporting responsibilities
- Performance payments
  - Payment terms
  - Performance measures and targets
  - Performance period and glidepath to more advanced categories
- Provider participation requirements
- Risk adjustment, if applicable to the VBP
- Contract terms for modifying or terminating the agreement

It is important to familiarize you and your staff about contracting terms, key performance indicators, and monitoring a performance dashboard

CATEGORY 2C VBP: PAY FOR PERFORMANCE – KEY CONSIDERATIONS

- Choose Metrics
  - Which metrics are aligned with improved patient outcomes and align with the practice's improvement strategies?
  - Which metrics have a direct financial implication for the health plan (premium withhold, member auto assignment)? What is the magnitude of those implications to the health plan?
  - Is it a manageable number of metrics; do they align with other payers?
  - Can you make a difference in the metrics? (is there room for improvement, access to timely information, ability to impact with CM and/or clinical model?)
- Agree on the patient attribution methodology
- Gauge current performance vs. target performance
- Data
  - Require at least monthly updates to a provider portal that allows identification of patients out of compliance with the metric
  - Agree on a mechanism to correct discrepancies with supplemental data
- Negotiate tiered payments based on improvement and attainment
- Negotiate a payment that will engage providers across the practice

CATEGORY 2C VBP: PAY FOR PERFORMANCE – KEY CONSIDERATIONS (continued)



- Start the program in year one using your own or the plan's benchmark as baseline (versus national benchmarks)
- Understand whether you will be subject to outcomes for members being transferred from other providers when it is too late to impact performance
- Understand whether your payment is based on your performance or whether it is subject to total plan performance
- Bonus payments for P4P performance should not be counted as a cost in category 3 or 4 VBPs, especially when there is a separate source of plan revenue such as premium withholds
- Understand what would happen if the agreement can be terminated mid-year
- Agree on detailed terms before signing a contract

STRATEGY FOR DETERMINING QUALITY MEASURE PERFORMANCE TARGETS

Improvement and attainment of performance targets:

Attainment Goal (75th percentile)			80%
Improvement Goal over Baseline			5%
	Baseline Score	**Performance Target**	
Practice #1	40%	42%	
Practice #2	60%	61%	
Practice #3	90%	80%	

CATEGORY 3A: VBP WITH UPSIDE GAINSHARING

LAN Category 3 VBPs encourage providers to deliver effective and efficient care

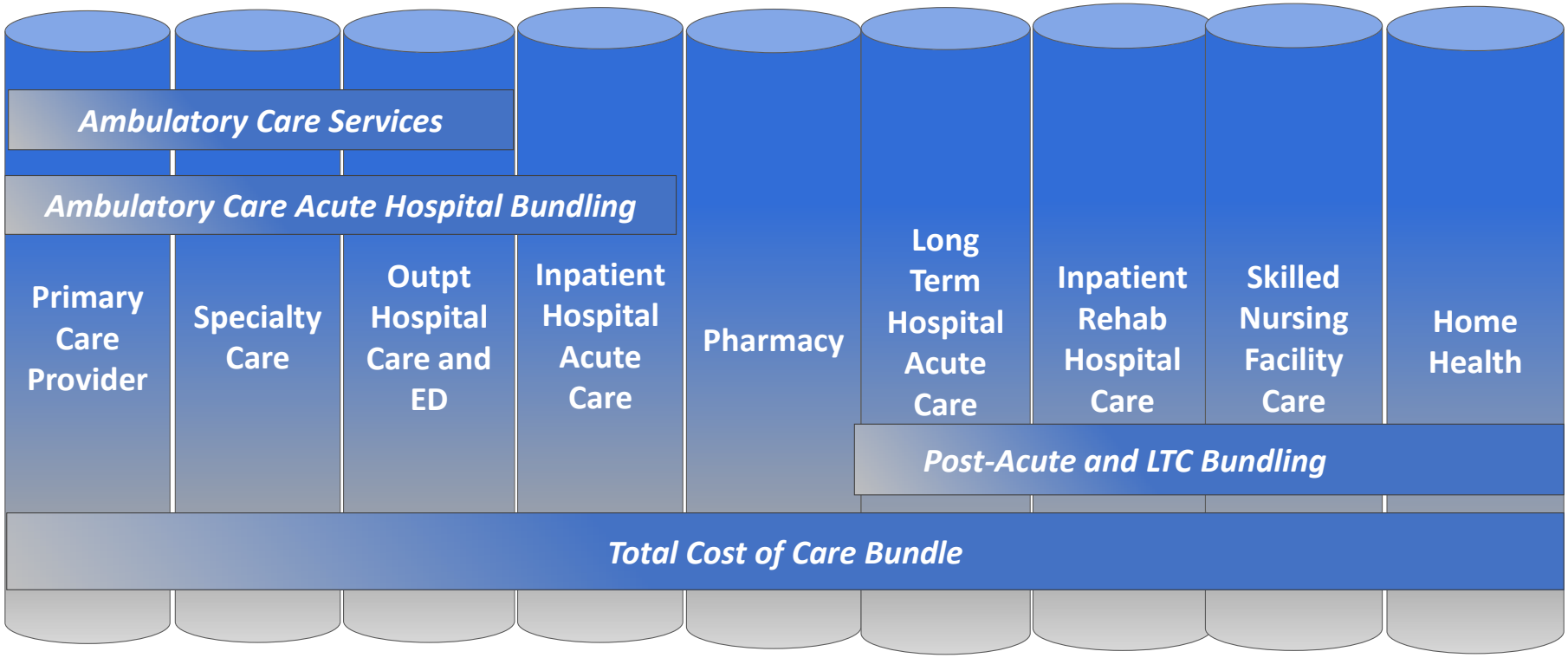
- Episode-based and other types of bundled payments encourage care coordination because they cover a complete set of related services that may be delivered by multiple providers
- Holds providers financially accountable for performance on appropriate care when patients receive the right care at the right time in the right place and at the right intensity

For LAN 3A shared savings payment arrangements, it is important to discuss and agree on these additional contractual elements beyond what is needed for LAN 2C VBPs:

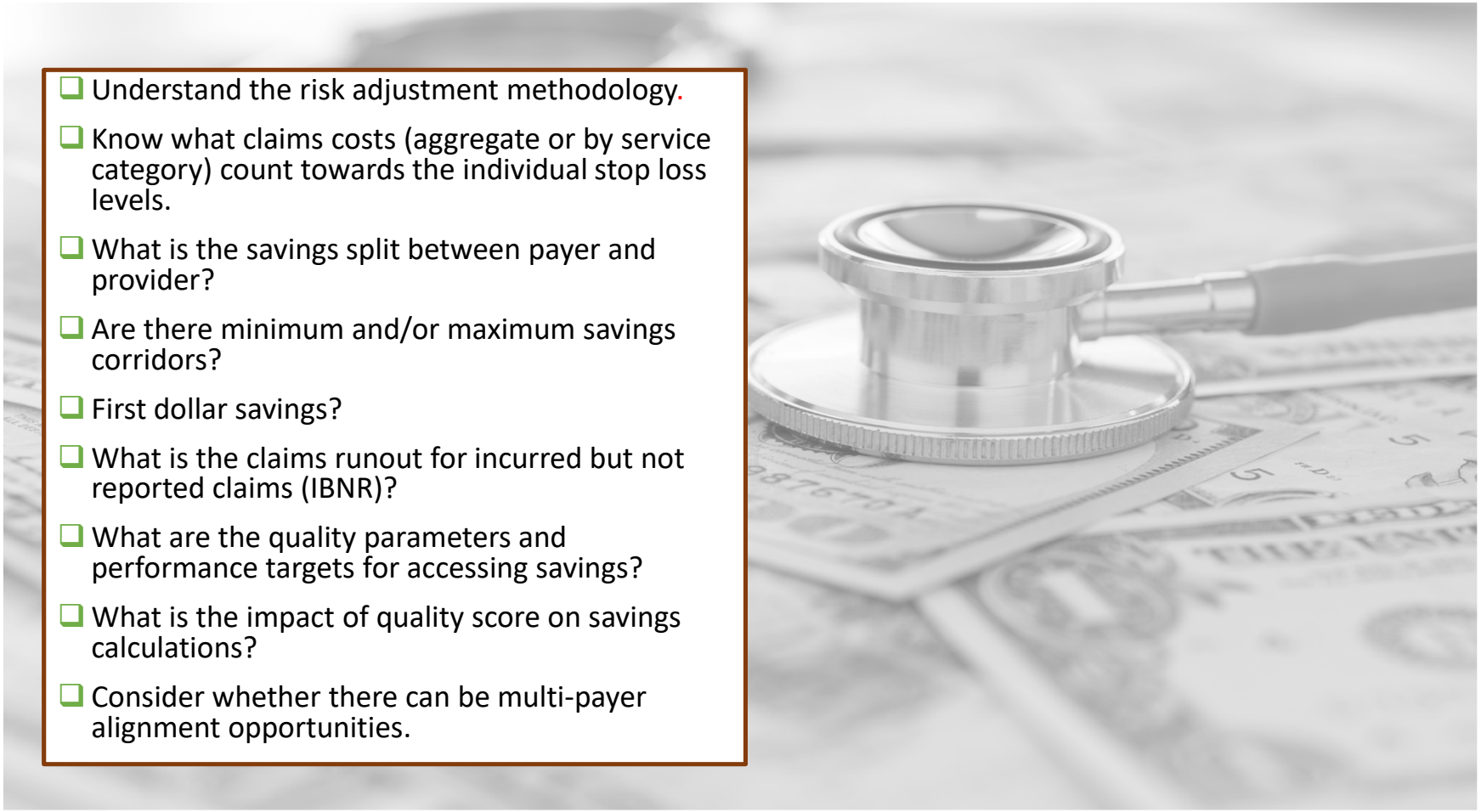
- Minimum attributed membership
- Triggering events/episode definition
- Inclusion or exclusion of value-added benefits
- Accounting for cost of the care management fee and Category 2 P4P VBP funds
- Benchmark
  - Basis for the benchmark spend (percentage of premium, historical spend of assigned members)
  - Annual trending of the benchmark spend
  - Frequency of resetting the benchmark spend

CATEGORY 3A: UPSIDE GAINSHARING

What bundle of services can I manage and what do I want to be accountable for now versus over time?



LAN CATEGORY 3A: VBP WITH UPSIDE GAINSHARING – ADDITIONAL CONSIDERATIONS



- ❑ Understand the risk adjustment methodology.
- ❑ Know what claims costs (aggregate or by service category) count towards the individual stop loss levels.
- ❑ What is the savings split between payer and provider?
- ❑ Are there minimum and/or maximum savings corridors?
- ❑ First dollar savings?
- ❑ What is the claims runout for incurred but not reported claims (IBNR)?
- ❑ What are the quality parameters and performance targets for accessing savings?
- ❑ What is the impact of quality score on savings calculations?
- ❑ Consider whether there can be multi-payer alignment opportunities.

LAN CATEGORY 3B OR 4: MOVING TO SHARED SAVINGS/DOWNSIDE RISK

Moving into LAN Category 3B or 4 will provide further opportunity for shared savings but also adds downside risk if the actual population cost is above the contract budget and/or minimum quality goals are not met

If that risk occurs, it can result in a loss such as

- Provider is responsible for a portion of the amount over budget (shared losses), or
- Forfeit all or a portion of a withhold

Medicare's Quality Payment Program (QPP) is an example of shared savings/losses:

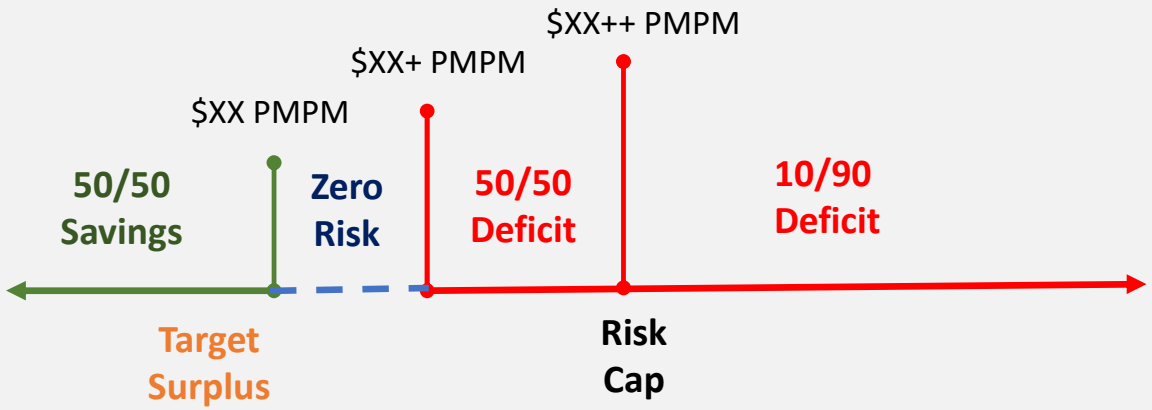
- The QPP's Merit-based Incentive Payment System (MIPS) pays a percentage of the Medicare Physician Fee Schedule based on performance in four categories – quality, cost, improvement activities, and advancing care information – can result in a reduction in payment if not meeting performance standards
- Clinicians can also receive a portion of their Medicare Part B payments through participation in one or more "Advanced APMs" that may include downside risk

LAN CATEGORY 3B OR 4: RISK MITIGATION STRATEGIES

- Demonstrate ability to generate shared savings before progressing to shared risk
- Assure panel size is enough to minimize the impact of statistical variation in performance
- Negotiate a minimum loss ratio (MLR) for the VBP arrangement
- Negotiate stop loss and risk corridors
- Negotiate an approach to mitigating shared losses if perform well on the quality metrics
- Consider clinical and financial integration with external provider partners
- Take risk only for services you can reasonably impact
- Build an adequate reserve pool using some of the early year savings
- Pursue a multi-payer approach
- Act now as if you were taking capitated risk

OPTIMIZING FINANCIAL OUTCOMES: INDIVIDUAL STOP LOSS, LOSS RATIOS, AND RISK CORRIDORS

Shared Savings & Risk Structure



Highlights

- Surplus opportunity tied to Plan's break-even rate
- Individual stop loss minimizes insurance risk
- Risk corridors mitigate aggregate downside risk

LAN CATEGORY 3B OR 4: CONTRACT TERMS EXAMPLE

Shared Savings/Risk Example for a Clinically Integrated Network	
Defined population	Assigned members for every month of assignment
Minimum assigned membership	2,000
Service exclusion	Long term supports and services (LTSS), pharmacy
Setting the baseline (% premium vs historical spend)	85% in Year 1; medical loss ratio that is a 1% improvement over previous year experience beginning in Year 2 but never <85%
Risk adjusted benchmark	Yes
Trending the benchmark	Benchmark tied to percentage of premium so adjusted in parallel fashion
Claims run out period/IBNR	Six months with IBNR calculation using actuarially sound principles; The clinically integrated network (CIN) may request verification by an agreed upon external actuary at the sole expense of CIN
Sub capitated services to other vendors	At actuarially sound rates when that vendor is an affiliate of the health plan; CIN may request rate verification by an agreed upon external actuary at the sole expense of CIN
Minimal savings threshold	None
High-cost claimants	$100,000 threshold with 90% coverage of claims overage
Shared Saving %	50%
Shared Savings Qualifiers	Tied to 5 of the metrics that payer is responsible for, each weighed at 20%, chosen at CIN discretion

RISK ADJUSTMENT CHALLENGES

Risk adjustment for your patient/client population is important for successful performance under VBPs

- Most risk adjustment is based on the presence of chronic diseases
- We don't have adequate or high-fidelity risk adjusters for children or populations burdened by social determinants (yet)

Impact of VBPs on communities experiencing health disparities is a concern and we don't have good information on impacts for those populations/communities

- Providers should have an explicit organizational plan to address racial/ethnic equity
- Collect accurate demographic data in the EHR to measure and address health disparities.
- Tie internal incentives to address health inequity
- Include providers and patients from communities experiencing disparities in the VBP governance structure and implementation strategy

ANALYTICAL RESOURCES AND TRACKING OUTCOMES

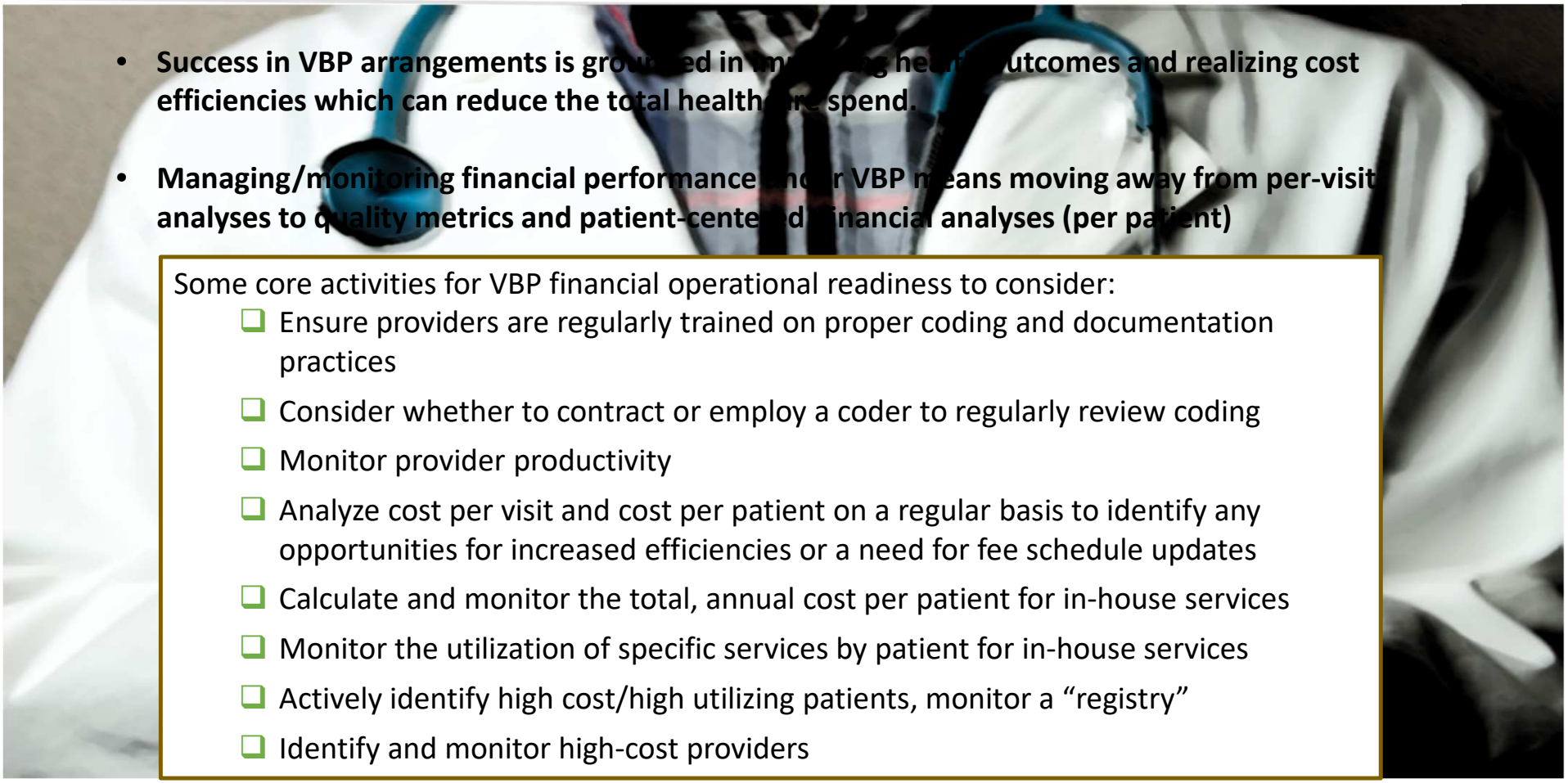
Effectively managing populations of patients require practices to have accurate and comprehensive data that can be analyzed and acted upon – this is essential to success with a value-based payment arrangement.

The contract should clearly outline obligations of both the payer and the provider regarding submission and reporting of data

Data Monitoring/Quality Improvement:

- Does your practice/organization have the technology to support retrieving, storing, calculating and reporting clinical quality metrics?
- Are your quality/outcome measures reviewed with clinical leadership, providers, and administration?
- Does your practice utilize quality reports/data to inform patient outreach when appropriate?
- Are you able to use patient/member data from payers in conjunction with program data for measures reporting, retrospective analytics and continuous program improvement purposes?

ANALYTICAL RESOURCES AND TRACKING OUTCOMES



- **Success in VBP arrangements is grounded in improving health outcomes and realizing cost efficiencies which can reduce the total healthcare spend.**
- **Managing/monitoring financial performance under VBP means moving away from per-visit analyses to quality metrics and patient-centered financial analyses (per patient)**

Some core activities for VBP financial operational readiness to consider:

- ❑ Ensure providers are regularly trained on proper coding and documentation practices
- ❑ Consider whether to contract or employ a coder to regularly review coding
- ❑ Monitor provider productivity
- ❑ Analyze cost per visit and cost per patient on a regular basis to identify any opportunities for increased efficiencies or a need for fee schedule updates
- ❑ Calculate and monitor the total, annual cost per patient for in-house services
- ❑ Monitor the utilization of specific services by patient for in-house services
- ❑ Actively identify high cost/high utilizing patients, monitor a "registry"
- ❑ Identify and monitor high-cost providers

CONCLUSION/SUMMARY

- LAN Categories of value-based payment progressively move away from fee-for service payments towards population health-focused payments.

- Oregon CCOs and other payers will be increasing the minimum percentage of total provider payments that would fall at or above LAN Category 2C over the next few years.

- Understanding key contract terms is critical for your practice as you discuss VBP contracts.

- For Pay for Performance (LAN 2C), important aspects to consider:
  - The quality metrics are achievable commensurate with the capacity to measure and report
  - A patient attribution methodology that is well understood

- And when moving beyond Pay - for - Performance to Shared Savings and Downside Risk additional key elements are:
  - The population is well-defined, with a minimum assigned membership
  - The services to be delivered or excluded are clearly described
  - Clear benchmarks are set with risk corridors and stop loss to define downside risk

- Analytical capacity and tracking of outcomes is essential – this can include performance data monitoring and analysis that can be acted upon, but also understanding your financial and operational readiness

RESOURCES

- OHA-CCO VBP Roadmap Updated November 2020 available at: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/OHA%20CCO%20VBP%20Technical%20Guide%20November%202020%20Update.pdf
- Oregon's VBP Compact (March 2021) available at: http://www.orhealthleadershipcouncil.org/oregon-value-based-payment-compact/
- OHA's Value-based Payment Toolkit for CCOs
  - Elements of value-based payment contracting: a guide for health care plans and health care providers – available at: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/VBP-Contracting-Elements-Checklist.pdf
  - VBP contracting elements checklist: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/VBP-Contracting-Elements-Checklist.pdf
- University of Washington VBP Toolkit: https://depts.washington.edu/fammed/wp-content/uploads/2017/11/VBP-Toolkit-17-1107.pdf
- American Academy of Family Practice's performance measures considerations: https://www.aafp.org/about/policies/all/performance-measures.html
- Health Care Payment learning & Action Network (LAN) "Foundational Resources" which include papers and Fact sheets on Data Sharing, Financial Benchmarking, Patient Attribution and Performance Measurement are available at: https://hcp-lan.org/foundational-resources/

RESOURCES CONTINUED

- Milliman's Patient Attribution Brief: https://www.milliman.com/-/media/milliman/importedfiles/uploadedfiles/insight/healthreform/whose-patient-is-it.ashx
- McCoy RG, et al *"Patient Attribution: Why the Method Matters",* American Journal of Managed Care. 2018 Dec; 24(12): 596-603 available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6549236/
- Medicare's Quality Payment Program – more info available at: https://qpp.cms.gov/about/qpp-overview
- *"Risk Stratification: A Two-Step Process for Identifying Your Sickest Patients" Fam Pract Manag.* 2019 May-June;26(3):21-26 available at: https://www.aafp.org/fpm/2019/0500/p21.html
- National Association of Community Health Centers (NACHC) Risk Stratification Action Guide available at: https://www.nachc.org/wp-content/uploads/2019/03/Risk-Stratification-Action-Guide-Mar-2019.pdf
- *"A Practical Risk Stratification Approach for Implementing a Primary Care Chronic Disease Management Program in an Underserved Community"* J Health Care Poor Underserved 2018; 29(1): 202-213 available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6360936/

Q & A

Send your questions to the host via the Question function.

UPCOMING FROM THE OHA TRANSFORMATION CENTER

- Please complete the evaluation that will be sent out after the webinar.
- CME credit will be emailed to participants completing the evaluation.
- Slides, webinar recording will be available at: **https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Value-Based-Payment.aspx**

- Next session: **May 19, 2021, Noon to 1pm**

  Topic: Learnings from COVID-19 and how they may impact the adoption of value-based payments

- Follow-up questions?

  Contact: **OHAVBPQuestions@healthmanagement.com**