ALTERNATIVE REIMBURSEMENT MODELS

A Practical How-To Guide
Agenda

Part 1
November 26, 2018; 1-3pm

1:00-1:15 PM   I.  Learning Objectives
1:15- 2:00 PM  II. Overview Of Reimbursement Models: Pros & Cons
2:00-2:30 PM   III. Best Practices & Lessons Learned
2:30-3:00PM    IV. Q&A

Part 2
December 3, 2018; 1-3pm

1:00-1:15 PM   V.  Quick Recap of Part 1
1:15-2:00 PM   VI.  Success Factors & Case Studies
2:00-2:30 PM   VII. Practicum – How To Walk Through The 10 Steps Of VBR With A Payer
2:30-3:00PM    VIII. Q&A
Learning Objectives

1. **Understand**
   Understand the types of alternative reimbursement models available, pro’s and cons to each, and learn the practical “how to’s”

2. **Explain**
   Explain the 10 steps to take to develop a successful value-based reimbursement (VBR)

3. **Identify**
   Identify how to overcome common barriers to successful VBRs, including how to work with payers

4. **Describe**
   Describe lessons learned and best practices, including case studies
Overview of Reimbursement Models

Pros & Cons
This Framework represents payments from public and private payers to provider organizations (including payments between the payment and delivery arms of highly integrated health systems). It is designed to accommodate payments in multiple categories that are made by a single payer, as well as single provider organizations that receive payments in different categories—potentially from the same payer. Although payments will be classified in discrete categories, the Framework captures a continuum of clinical and financial risk for provider organizations.
Reimbursement Types

1. Fee-for-service
2. Pay for performance
3. Case rate or bundled rate
4. Diagnosis Related Group (DRG)
5. Shared savings and shared risk
6. Capitation
Reimbursement Types: Fee-For-Service (FFS)

**Definition:** Separate payment to a health care provider for each unbundled medical service rendered to a patient

**Pros**
- Payments match services
- Complete utilization data
- More transparency
- Provides audit trail

**Cons**
- Incentivizes over utilization
- Rigid and stands in the way of innovation
- Discourages efficiencies of integrated care

**FFS Example**
- “ABC” Health Plan pays a flat rate of $110 for CPT 90791 for a qualified, credentialed, independent licensed provider
- “XYZ” Heath Plan pays a flat rate of $750 for Rev code 124 for acute inpatient level of care after approved authorization
Reimbursement Types: Pay For Performance

**Definition:** Providers are financially rewarded for meeting pre-established targets for delivery of healthcare services

**Pros**
- Incentivizes behavior change
- Lead to improvement of quality measures
- Encourage more efficient coordination

**Cons**
- Provider only focused on care that affects measures, and ignore other factors - “manage to metric” or “cherry pick” member
- Incentive may not be large enough to promote behavior change
- Provider could see overall reduction in revenue if unable to fill vacancy
- Difficult to evaluate causality v. random fluctuation

**Pay For Performance Example**
- “ABC” Health Plan pays an escalator of up to 6% for rev code 124 (acute inpatient level of care) based on achievement of HEDIS 7-day ambulatory follow up
- “ABC” Plan pays a 1 time bonus of $50,000 for achievement of key performance measures included assuring consumer compliance with annual dentist visit
Reimbursement Types: Case Rate or Bundled Rate

**Definition**: A flat payment for a group of procedures and/or services

**Pros**
- May decrease need for authorization and concurrent review
- Controls cost per episode
- Incentivizes fewer re-admissions
- Can bundle multiple services and promote innovation

**Cons**
- Incentivizes shifting treatment to other settings or codes
- Increase oversight to manage quality
- Increases risk to providers
- Potential for double payment if member switches provider
- Encourages discharge once member passes breakeven point
- Incentivizes admissions
- Need to make many assumptions, e.g., service mix, license mix, etc.
- Requires system to support

**Case Rate Or Bundle Rate Example**
- “ABC” Health Plan pays a monthly rate of $1,200 for Medication Assisted Treatment (MAT) to include medication management, counseling services, and lab services associated with treatment, excluding medication costs.
- “XYZ” Health Plan pays a case rate of $7,000 for acute inpatient episode to include all services (e.g., physician fees, labs, etc.) for a single treatment episode. A readmission warranty includes a 10% withhold for any case that is readmitted within 90 days of treatment.
- “EFG” Health Plan pays a tiered case rate of $800 for day 1 of treatment, $600 for days 3-5, and $200 for Days 6 and 7 with no payment after day 7 for acute inpatient treatment.
Reimbursement Types: Diagnosis Related Group (DRG)

**Definition:** A flat payment for a bundled group of procedures and/or services that are needed to treat a particular disease

**Pros**
- Single predictable payment allows provider to manage services
- Generally state of CMS-defined

**Cons**
- May not include outlier protocols for complex cases
- May be more medically driven
- May focus scrutiny on admission approval

**DRG Example**
- “ABC” Health Plan pays 100% of the state-defined DRG with no outlier methodology.
Definition: Provider and payer share in the healthcare savings pool generated by performance improvement (e.g., reduced behavioral costs or total cost of care)

Pros
- Offer a reward split among those contributing to the success (e.g., payer supports analytics and member assignment and provider implements interventions to reduce costs)
- Shared risk is a variation in which the provider is “at risk” for the service costs
- Good step toward capitation if successful

Cons
- “Shared” is not always a 50/50 share
- Achievement may result in little room for ongoing improvement—need to develop go-forward model of sustainability

Shared Savings & Shared Risk Example
- A Core Service Agency (CSA) offers a full continuum of care and has been assigned 500 seriously and emotionally disturbed (SED) children to manage with a goal of improving community tenure and reducing out-of-state foster care placement. Achievement of pre-defined target measures (using baseline year of data) will result in the Plan and the CSA splitting the savings (generated from reduced higher level of care costs) 50/50
- Variation – CSA is at risk for the membership and splits any achievement with the Plan, but must pay all services and provide transparency into service utilization and costs
Reimbursement Types: Capitation

**Definition:** A set payment for each enrolled person assigned to that physician or group of physicians, whether or not that person seeks care, per period of time

**Pros**
- Rewards groups, and in turn those groups’ individual physicians, who deliver cost-efficient care
- Costs stable and predictable
- No billing

**Cons**
- Assignment can be challenging in behavioral health environment
- Payers concerned that under-treatment might occur
- Dependent on marketplace factors and a group’s negotiating power
- May result in increased oversight by payer
- Regulatory hurdles
- Requires system to support

**Capitation Example**
- An outpatient provider is paid a per member per month (PMPM) to support the care coordination of an assigned cohort of 500 individuals that meet the state definition of severe and persistently mentally ill (SPMI). The provider can earn a bonus on top of the PMPM if key performance measures are achieved.
### Key Components Of Performance-Based Contracts

#### Entry Level Criteria

- Submit claims electronically with fast turn around time and/or have data sharing capabilities
- Participate in review and intervention discussion (e.g. once a month)
- Adhere to current managed care requirements and clinical guidelines

#### Measures

- Balance of Quality and Cost/Efficiency Measures with Social Determinants of Health tracking
- Emphasis on outcome vs treatment process measures
- Examples: PCP visit in past 12 months, #/% employed in integrated program, wages earned over 2 week in paid community job, national core indicators (NCI)

#### Rewards

- Annual escalator
- Bonus payment
- Prorated based on performance to capped amount
## Most Commonly Used Performance Measures Of Specialty Provider Organizations, 2016-2018

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow-up after hospitalization for mental illness</td>
<td>Hospital readmission rates, patient or consumer satisfaction</td>
</tr>
<tr>
<td>Emergency room utilization</td>
<td>PCP Engagement, access to care measures</td>
</tr>
<tr>
<td>Readmission rates</td>
<td>Diabetes screening for people with Schizophrenia using an antipsychotic</td>
</tr>
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<td>Diabetes care—blood sugar controlled</td>
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<td>Patient Reported Outcomes</td>
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<td>Involvement of family/significant other</td>
<td>Use of depression screening and follow-up</td>
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The Intersection Of Value-Based Reimbursement (VBR) & Social Determinants Of Health (SDOH)

**VBR**
Ties reimbursement to quality and efficiency measures

- Facilitates the achievement of the triple aim—improving population health, reducing the costs of health care and improving individual member outcomes
- Supports provider engagement and payer/provider collaboration
- Rewards provider performance on agreed upon measures of quality and utilization

**SDOH**
Environmental factors that influence a population’s health and functioning (e.g., socio-economic status, transportation, age)

- Provide important detail that can guide interventions to achieve VBR goals
- Increase understanding of population needs
- Move VBR beyond easy-to-access measures that hold greater meaning
What is the return on investment in collecting social determinants of health?
Best Practices & Lessons Learned
Why Value-Based Reimbursement Fails

Organization lacking:
• Review and collaboration around results
• Development of targeted interventions
• Visibility to key stakeholders
• Population of focus is unclearly defined

Example:
• No meetings to review scorecards/email distribution
• Interventions lacking – not developed or not monitored
• Results not cascaded to key decisionmakers and action takers
• Lack of understanding of population characteristics and social determinants of health
Organization has:

- Population cohort clearly defined
- Regularly monthly meetings to review results at the case level with decisionmakers, key stakeholders, and action takers
- Interventions developed with close monitoring of follow-through and impact on results

Example:

- Individuals meeting state definition of seriously and persistently mentally ill (SPMI) with collection of social determinants of health to include developmental delays, caregiver supports (e.g., transportation, respite), etc.

Findings: Consumer with the least progress on the quality and utilization outcomes measures were those with co-morbid developmental delays and behavioral health needs. Gaps in care including respite services, transportation and services for those with dual diagnoses were tackled as part of the actions taken through joint efforts by the payer and provider team.
How To Overcome Some Of The Pitfalls Of VBR Failures

- Get Payer **Buy-in**
- **Leverage** Electronic Health Record (EHR)
- **Engage** the right stakeholders
- Design interventions with those closest to the process with **visibility** to key leaders
Value-Based Reimbursement Checklist

- Gather the right team
- Define the goal (e.g., reduce out-of-state placement for foster care)
- Establish the metrics – both quality and utilization management with clear definitions and design the data collection process to include both measures of performance success and population health characteristics confirm
- Approach payer with clear, succinct proposal that includes financial model and anticipated return on investment
- Develop regular structure for reporting (e.g., scorecards), monitoring and evaluation to include intervention development
- Collect and analyze data.
- Develop interventions based on analysis.
- Monitor intervention impact.
- Review interventions based on outcomes.
- Maintain monitoring and evaluation efforts.
Managed Care Principles & Implications To Value-Based Reimbursement
Managed Care Principles

ACCESS, COST, QUALITY

Quality
- Member- and care-giver reported outcome measures
- Access to high quality services
- Provider Profiling

Cost Management
- Least restrictive setting
- Medical/service cost management
- Unit cost trends

Data-Driven

Population Health
- Planning tied to population characteristics
- Interventions tied to better understanding of population health and desired outcomes

Evidence-Based Care
- New treatments and technologies
- Decisions based on clinical guidelines
Managed care and providers agree on the Triple Aim.

- High quality services in the least restrictive setting
- Broad system of services, including natural supports
- Consumers are empowered and engaged
Tools to Improve Quality & Cost Outcomes

Provider-Focused Tools

- High-performance networks and providers, including Centers of excellence
- Delivery system innovation, such as patient-centered medical homes and accountable care organizations (ACOs)
- Electronic medical records (EHRs), apply population health characteristics
- Information exchanges and learning collaboratives
- Pre-service / concurrent / retrospective review and physician education
- Outpatient, inpatient, and pharmacy utilization review
- Provider performance measurement and quality improvement programs
- Value-based provider payments

Core Tools

- Benefit plan design
- Medical necessity clinical guidelines and medical/service policies
- Coverage determination guidelines
- Appeals and grievances for members and for providers
- Technology assessment

Member-Focused Tools

- Health and wellness programs
- Case management
- Disease or condition management
- Care coordination
- Transparency re: provider performance
- Consumer-directed incentives for healthier behavior
- Value-based benefits, including tiered benefit and rewards to seek services with high value providers

Provider & Member-Focused Tools

- Health care information technology
- Sophisticated clinical analytics to identify gaps in care and in affordability
- Collaborative measurement projects, using multi-payer claims databases
- Administrative simplification through automation
Intervention Effectiveness

- Effectiveness of typical interventions plotted against the relative cost per consumer to implement.
- For example, incentives may be effective an intervention as benefit design is far more expensive to implement.
Develop positive payor relationships

Evaluate measure collection and analysis against measures expected by payors/state

Understand unit costs and improvement opportunities

Review current workflows against managed care requirements (e.g., authorization rules, reports)
Q&A
Part II
Success Factors & Case Studies
Managed Care Principles

1. Embrace Change

2. Develop Payor Relationships

3. Establish Or Revise Key Performance Indicators

4. Embrace Technology & Innovation

5. Think Collaboratively
Success Factor #1: Embrace Change

Key Principles

1. Be a change leader; create a culture that is able to flex and rewards flexibility.

2. Address both the rational reason for the change and the emotional case - what’s in it for me (WIFM).

3. Assess and communicate, communicate, communicate.

4. Start at the top but involve every mind.

5. Identify and celebrate small wins; break the change into smaller components.

6. Celebrate success!
Success Factor #2: Develop Payor Relationships – $P^3=W^3$

- Know what the payer needs and wants.
- Get to know key payer leaders/decision makers on a personal level.
- Pitch a pilot that resonates with the payer’s needs and the provider organization’s needs - Payer/Provider Pilot.

- Community Mental Health Center (CMHC) and payer concerned about medication adherence of high risk members
- Engaged vendor who specialized in co-located pharmacies that offer specialized adherence packaging, consults, alerts, member education, refill reminders, and reporting
- RESULT: $58 PMPM savings; Incentive payment for the CHMC.
## Success Factor #3: Establish Or Revise Key Performance Indicators

<table>
<thead>
<tr>
<th>Follow-up after hospitalization</th>
<th>Emergency room utilization</th>
<th>Readmission rates</th>
<th>Consumer &amp; caregiver satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of evidence-based care protocols</td>
<td>Access to services measures</td>
<td>Diabetes screening</td>
<td>Medication Adherence</td>
</tr>
<tr>
<td>Appropriate referrals to other providers</td>
<td>Depression monitoring via PHQ-9</td>
<td>Consumer employment</td>
<td>Involvement of family/significant other</td>
</tr>
<tr>
<td>Annual eye exam</td>
<td>Consumer reported health measures</td>
<td>Annual Dentist Visit</td>
<td>Annual Physical (PCP engagement)</td>
</tr>
</tbody>
</table>
Defining Outcomes: Measure Performance With Defined Outcomes

Measuring Treatment & Service Response

- Measuring treatment response is an effective quality measure.
  - Depression screenings
  - Initiation and maintenance of antidepressant medication therapy
  - Depression remission
  - Identification and treatment of substance use disorders

Process Measures

- These typically illustrate provider or consumer adherence to care improvement processes and are substitutes when outcomes may be difficult to calculate.
  - Scheduling appointments for 7- and 30-day follow-up after hospitalization for mental illness
  - Treatment initiation and engagement benchmarks for substance use disorder
  - Notification of inpatient admission

Outcome Measures

- These are quantitative outcomes that demonstrate whether or not a targeted goal was achieved.
  - Actual percentage for 7- and 30-day readmissions
  - Actual percentage of “kept appointments” for 7- and 30-day follow-up after hospitalization for mental illness

Social Determinants Of Health Measures

- Many behavioral health conditions contribute directly to deficits in social determinants of health. Measurements of social determinant outcomes can illustrate high quality behavioral health outcomes.
  - Employment status
  - Housing status
  - Education status
  - Quality of life
  - Independent living
Success Factor #4: Embrace Technology & Innovation

The 2025 Prediction:

“Any-Time, Any-Place, Continuous & Personalized Care. . .

An ecosystem of devices and sensors which:

- Capture & Measure
- Identify
- Stratify Risks
- Inform
- Make Decisions
- Take Action
Success Factor #4: Treatment-Enabling Technologies Available All Along The Service Continuum

Diagnostics
- Tele-psychiatry using IronWorks™
- M3 (My Mood Monitor™)
- Brain scanning tech

Education/Decision Support
- Video Doctor
- Common Ground
- Virtual Handheld Clinic
- PTSD Coach
- True Colours
- ChronoRecord
- Health Steps for Bipolar
- Biomarker: BDNF levels
- myStrength

Clinical Treatment
- TMS Therapy®
- Beating the Blues
- SilverCloud

Cognitive Function Restoration
- My Mood Map
- eCBT Mood©
- MyBrain Solutions

Early Detection of Relapse
- Automatic Trail Making Tests™
- fMRI
- ITAREPS
- MONARCA
- Actiwatch
- Health Buddy®
- OPTIMI

Relapse Prevention
- Technology Enhanced Recovery™
- REAC-CRM (REAC-lithium)
- PSYCHE
- Personalised Ambient Monitoring (PAM)
- MoodMapping

Monitoring of Patient Health
- ViTelCare™ T400
- SenseWear® Armband System
- MagneTrace
- ID-Cap
- Electronic Medication Management Assistant® (EMMA)
- Implantable RF Transceiver ZL70102
- Motionlogger Actigraph
- Helius™
- MOBUS

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Success Factor #4: The Human Support Factor

Coach-supported web-based interventions
• Are effective (ds=.56 – 1.08)
• Patients are adherent (~9 logins)

Coaches do not need to be mental health professionals
Success Factor #5: Collaborative Care Model (CoCM)

Rewards PCP and multi-disciplinary treatment team to screen members for anxiety and depression.

Virtual psychiatrist provides consultation to PCP for complex cases.

Embedded care manager coordinates care and updates data register.

Diagram:
- Primary Care Practitioner
- Consumer
- Behavioral Health Care Manager
- Virtual Psychiatrist
Mental Health Case Study

Entry Level Criteria

- CMHC agrees to participate in monthly score card review
- Coordinate with Primary Care Physician (PCP) and other specialty providers to support medical Healthcare Effectiveness Data and Information Set (HEDIS) measure improvement (e.g. Dental appointments)
- Support collaborative care model by offering care coordination support and/or virtual prescriber access

Measures

- Follow up within 7 days post inpatient discharge and 7 days post Emergency Room (ER) visit.
- Diabetes screening
- Community tenure

Rewards

- PMPM bonus payment prorated by outcome results
Mental Health Case Study

Entry Level Criteria

- CMHC, Pharmacy programs agree to report measures and meet monthly to review scorecard and implement intervention
- Agreed upon roles and responsibilities regarding consumer engagement workflows

Measures

- Rx adherence measures by percentages of days covered for anti-psychotic medication
- Rx adherence measures by percentages of days covered for anti-depressant medication
- Rx adherence measures by percentages of days covered for diabetes medication
- Rx adherence measures by percentages of days covered for hypertension medication
- Medication gaps

Rewards

- PMPM bonus payment prorated by outcome results
All Types of Services Moving to Pay-for-Value

**Pay-for-value changes the rules** for service reimbursement – and opens up opportunities for leveraging new science and technology to reduce costs and improve consumer convenience.

- Specialty medical homes for consumers with serious mental illness (SMI), addictions, traumatic brain injury (TBI), Alzheimer’s, and chronic health conditions – with all care coordination services paid in per member per month (PMPM) payment
- Capitated contracts for Intellectual and Developmental Disabilities (I/DD) services – Kansas Medicaid and 18 other states to follow
- Capitated contracts for senior services (including nursing home care) planned for 19 state Medicaid plans
- Case rates for children’s services in child welfare system
- Case rates for TBI support services
- Voluntary self-directed I/DD services with individuals consumer budgets launching in California
Practicum

How To Walk Through The 10 Steps Of VBR With A Payer
The 10 Steps of VBR with a Payer

1. Assemble the Team
2. Define the Goal
3. Determine Metrics
5. Develop Reporting Structure
6-10. Launch: Collect, Develop, Monitor, Review, Maintain

The Value-Based Reimbursement Checklist
### Step 1: Assemble the Team
Include leadership for awareness and those directly engaged in implementation and monitoring

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Role</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>CFO</td>
<td>Name</td>
<td>Clinical Leader</td>
<td>Name</td>
</tr>
<tr>
<td>CEO</td>
<td>Name</td>
<td>Billing</td>
<td>Name</td>
</tr>
<tr>
<td>COO</td>
<td>Name</td>
<td>Team/Unit Leaders</td>
<td>Name</td>
</tr>
<tr>
<td>Data/Reporting/Analytic</td>
<td>Name</td>
<td>Others</td>
<td>Name(s)</td>
</tr>
<tr>
<td>Support</td>
<td></td>
<td>(Direct control over implementation of intervention or vested interest)</td>
<td></td>
</tr>
</tbody>
</table>

**Example:** A residential program seeking a VBC arrangement involved for awareness and buy-in: CEO, COO, and clinical leaders. Payer Relations & Finance Leader coordinated contract with payer review and approval of CFO/CEO. Achieving VBR reward required workflow changes and technology changes which required engagement of care team across all shifts; CTO to support availability of technology and discharge planner.
Step 2: Define the Goal

Example:

a. Reduce out-of-state placement for foster care
b. Increase community tenure
c. Improve consumer reported health & wellness
d. Reduce readmissions
e. Improve medication adherence
### The Value Based Reimbursement Checklist

#### Step 3: Determine Metrics

<table>
<thead>
<tr>
<th>(metrics)</th>
<th>Balance of Quality &amp; Efficiency metrics</th>
<th>Obtain payer and/or State feedback/input</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td></td>
<td>1. What measures is the State/Payer endorsing or incentivizing</td>
</tr>
<tr>
<td>b.</td>
<td></td>
<td>2. What pain points exist for payer/state client</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Consider social determinants of health (SDOH)</td>
</tr>
</tbody>
</table>

#### Metrics List

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<thead>
<tr>
<th>Quality:</th>
<th>Efficiency:</th>
<th>SDOH:</th>
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<tbody>
<tr>
<td>a) Consumer participates in annual PCP visit.</td>
<td>a) Community tenure</td>
<td>a) Consumer participates in annual PCP visit.</td>
</tr>
<tr>
<td>b) Consumer health outcome score improves on SF-12. change pre and post.</td>
<td></td>
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</tbody>
</table>

#### Example:

State offers incentive to improve 7 day follow up and PCP engagement. MBHO is missing targets on these measures.

#### Source:

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<tr>
<th>Quality:</th>
<th>Efficiency:</th>
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<tbody>
<tr>
<td>a) Health plan claims</td>
<td>a) Community tenure</td>
<td>a) Health plan claims</td>
</tr>
<tr>
<td>b) SF-12 collected by case based 12 months prior and 12 months post program engagement</td>
<td></td>
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#### Determine data definition and collection route

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# Step 4: Approach Payer With Proposal, Metrics, Financial Arrangement

## Meet with Payer
1. Reach as high into organization as possible – C-Suite
2. Learn payer pain points and objectives
3. Identify payer preferred provider programs
4. Seek congruence across payers

## Pitch the Idea
1. Keep proposal succinct – goal. measurable, objective, planned activities, return on investment
2. Illustrate this is a “win-win-win” for the payer, provider, and consumer
3. Find the WIFM (What’s in it for me?)

## Do Unit Cost Homework
1. Map activities and processes
2. Determine cost of each activity process
3. Determine service level unit costs
   - Costs per case
   - Understand drivers of cost variation
   - Cost per diagnosis and clinical path
   - Population cost distribution

## Finalize the Financial Arrangement
1. Consider an upside pay for performance as a 1st step (e.g. bonus for achieving outcomes) prorated against achievement
2. Risk share should aim for 50/50 split with estimated return on investment (ROI)
3. Bundle payments may fit if you offer an array of services each month – know your monthly costs.
Step 5: Develop Reporting Structure

It all starts with Structure

Structure → Process → Outcome

Develop regular structure for reporting (e.g. scorecards), monitoring and evaluation to include intervention development

a. Ideally, know your scores before the payer scorecard is released

b. Review case level detail weekly, monthly, and in aggregate

c. Capture root cause issues and interventions

d. Leverage EHR and SDOH data to avoid spreadsheet rainfall
The Value Based Reimbursement Checklist

Step 6-10: Launch

Launch
Collect and analyze data
Develop interventions based on analysis
Monitor intervention impact
Review interventions based on outcomes
Maintain monitoring and evaluation efforts.
Understand Process Improvement Opportunities

Referral & Intake
- Verifications
- Authorizations

Monitoring & Process Improvement
- Claims Analytics
- Process Improvement

Service Delivery
- Credentials
- Documentation

Billing & Collections
- Claims Submission
- Denials Management
- Payment Receipt & Posting
Strategic Financial Implications of Shifting Reimbursement Market

- Develop competencies and internal culture to compete in a performance-based market
- Develop infrastructure, information technology, and re-align processes
- Improve understanding of cost drivers – manage and reduce costs
How Does Activity Based Costing Work?

- Determine and manage the cost of services
- Evaluate outsourcing options
- Develop “What if” scenarios for service expansion or reduction
- Assist marketing staff in product design and service pricing
- Develop budgets
- Measure performance
- Evaluate the cost benefits of alliances or mergers