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Communimetrics Data Roundtable

Value Based Purchasing

February 1, 2018

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Agenda

- Hello!
- Update on Communimetrics on Wikipedia initiative (☹ ☹)
- Dan Warner, Ph.D., Community Data Roundtable's Executive Director

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Communimetric Data Roundtables

- Purpose: To support a community of professionals and scholars doing work in communimetrics.
- Chair: Dan Warner Ph.D. Executive Director of Community Data Roundtable
- Who is on this call: anyone on the data side of communimetric projects is invited to attend. (No matter at what level!)
  - Please state your name clearly when speaking/asking questions, so people can check the Phone Call Roster (link found in your calendar invite, and in the chat box.)
- All calls are video recorded and made available soon later.
- Feel free to use the chat feature to put in questions.
- We come together with a spirit of openness and sharing.

Communimetrics on Wikipedia

- Rejected again on October 6 for not having “reliable sources.”
- There are several Wikipedia pages on what reliable sources would be and how to put them into the page.
- Please consider checking out the page, and adding some reliable sources if you have them.
- https://en.wikipedia.org/wiki/Draft:Communimetrics

VALUE BASED PURCHASING

Value Based Purchasing
HealthCare.gov

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"Linking provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers."

Pennsylvania Behavioral Health Medicaid's VBP Framework (C/O Mercer (T. Dahl, et al)).

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Already in existence

CDR's Focus

Large, multilevel providers

Risk Category (Small, Medium, Large)	VBP Model	Description
S	1	**Performance-based Contracting (PBC):** Contracts in which payment is linked to provider performance and requires providers to undertake specific activities or meet certain benchmarks for services. These contracts may include incentives and penalties, caseloads and Pay-for-Performance.
M	2	**Bundled and Episodic:** A single bulk payment for all services rendered to treat an individual for an identified condition during a specific time period. These payments also include case rates.
M	3	**Shared Savings:** Supplemental payments to providers if they are able to reduce health care spending for a defined patient population relative to a benchmark. The payment is a percentage of the net savings generated by the provider.
M	4	**Shared Risk:** An arrangement of shared financial responsibility between payer and provider that allows for cost control, efficiency of service use and quality. In this arrangement, both financial savings and losses are shared.
L	5	**Capitation:** A payment arrangement for health care service providers that pays a set amount for each enrolled person assigned to them, per period of time, regardless of whether the person receives services during the period covered by the payment.
L	6	**Capitation + Performance-based Contracting:** This payment arrangement adds performance based contracting as a supplemental incentive to a capitation contract.

Asked to introduce a program that at least begins cost neutral

Communimetric Tools and VBP

- “Move from managing units, to managing transformations”
- In service industries every unit is treated the same, in transformation industries, every unit is treated according to its transformation needs
- Flexibility
  - To allow provider to make resource decisions
  - To address social determinants

What's in it for Providers

- More control over care
- Less tedious billing processes
- Change focus from units to outcomes
- Opportunities for financial maximization

- …But providers also pick up risk

Case Rates, Shared Savings, Shared Risks

Moderate risk

THE FOLLOWING SLIDES SHOW A VBP VISION BY EXTENDING CASE RATES INTO RISK SHARING

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Case rate

- Identify a service that has
  - a consistent Length of Stay;
  - a predictable cost for each interval of that LoS;
  - A communimetrically definable clinical population;
  - A communimetrically expected outcome profile for that population.
- E.g. Functional Family Therapy
  - 4 – 6 months
  - Approximately $6K a client episode
  - CDR FFT algorithm identifies appropriate FFT matches
  - CDR historical data shows us which items improve most meaningfully after intervention

Case Rate Shared Savings VBP Plan – Part 1

- When client matches a CDR program algorithm, members qualify for case rate program.
  - Reason: these profiles are empirically demonstrated to identify a population that matches what that treatment treats. CDR historical data shows outcomes.
- Reimbursement changes:
  - (1) Case Rate: Provider is paid a bulk sum for the entire treatment, and manages the dollars from there.
  - (2) Annual performance bonus: Population outcomes are assessed (see below), and provider success results in a “bonus” that the payer pools by using the case rate. (i.e. Shared savings)

Case Rate Shared Savings VBP Plan – Part 2

- Outcomes: Provider must attain outcomes on at least two levels:
  - (1) Meaningful change on the CANS profile for that program
  - (2) Level of Care step-down (also demonstrable historically)
- Risk consequences
  - Payer pays less than highs, more than lows. Reduces exposure & uncertainty. Can't sour, just might not benefit from all Provider discovered efficiencies.
    - Payer should keep aside a chunk that would be available for bonus.
    - Payer should pick a rate that can save them money in high clinical severity situations.
  - Provider has more leverage in distributing resources internally. Could sour if receiving a lot of tough cases (should use CANS to identify scenarios that if they sour, they are able to share the risk).

FFT VBP Example continued

- Currently, FFT billed in units on a weekly basis.
  - Note, authorization often allows a certain amount of units to be “drawn down,” so there is not a lot of current fighting about any given unit.
  - But submitting units is resource expensive for provider and payer.
- Currently, FFT struggles
  - EBPs are expensive (e.g. a lot of nonbillable time, EBP oversight costs, staff turnover)
  - EBPs compete in an information poor market (e.g. Many clients that are good for FFT never get there.)
- Currently, FFT is succeeding
  - The outcomes in the community of FFT (& other EBPs) continue to be positive, significant, and meaningful.

FFT Example: The Profile that matches.

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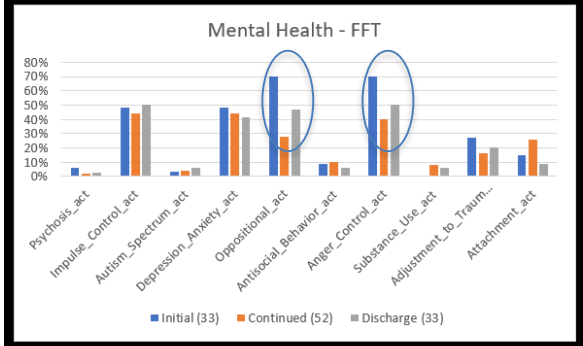
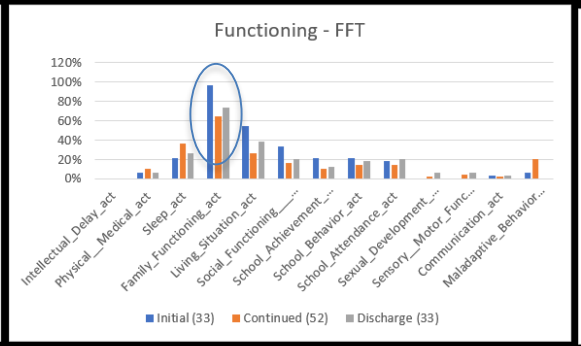
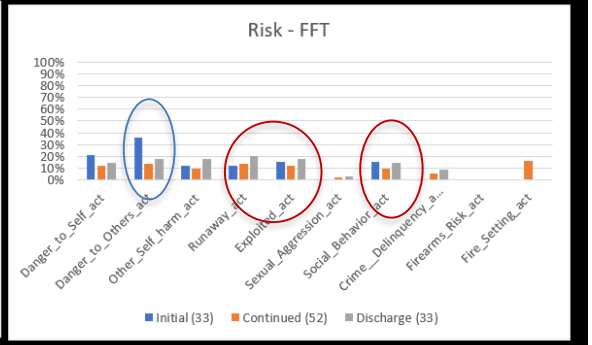
CSM Algorithm

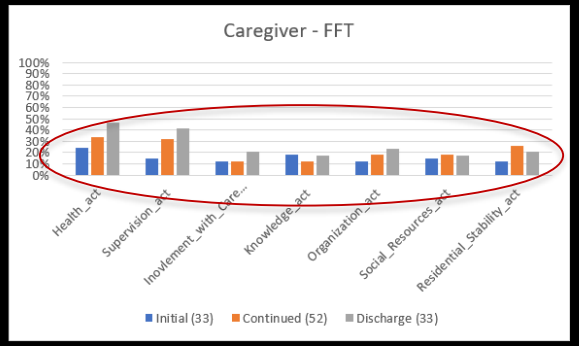
Age	&	Needs ≥ 2	&	Must Be ≥ 2	&	NOT ≥ 2	&	NOT = 3
10 - 18 Years		Oppositional Behavior		Family		Autism Spectrum		Psychosis
		Antisocial Behavior				Sexually Aggressive Behavior		Depression/Anxiety
		Anger Control				Communication		Danger to Self
		Danger to Others				Maladaptive Behaviors		Danger to Others
		Other Self Harm						Intellectual Disability
		Elopement						
		Exploitation						
		Social Behavior						
		Crime/Delinquency						
		Firearms Risk						
		Social Functioning - Peer						
		School Behavior						
		School Attendance						
		Supervision						
		Involvement						
		Knowledge						
		Organization						

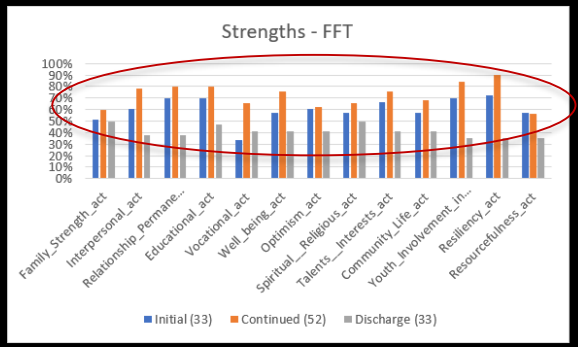
FFT Example: The Profile that matches.











FFT LOS/Cost analysis (fake numbers)

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Year/Month	Consumers	Sum of Dollars	Case Rate
FY 15/16 - FFT	**169**	**$ 1,000,000.00**	$ 5,917.16
Month 0	25	$ 32,000.00	$ 1,280.00
Month 1	22	$ 80,000.00	$ 3,636.36
Month 2	25	$ 135,000.00	$ 5,400.00
Month 3	50	$ 300,000.00	$ 6,000.00
Month 4	32	$ 300,000.00	$ 9,375.00
Month 5	14	$ 140,000.00	$ 10,000.00
Month 6	1	$ 13,000.00	$ 13,000.00
FY 16/17 - FFT	**157**	**$1,007,000.00**	$6,414.01
Month 0	17	$27,000.00	$1,588.24
Month 1	29	$100,000.00	$3,448.28
Month 2	33	$140,000.00	$4,242.42
Month 3	26	$200,000.00	$7,692.31
Month 4	33	$300,000.00	$9,090.91
Month 5	16	$200,000.00	$12,500.00
Month 6	3	$40,000.00	$13,333.33
Overall	326	$ 2,007,000.00	**$ 6,156.44**

With this number, you can pursue many different case rates, depending on your overall intentions.

Conclusion

- Communiteric data can form the basis of Value Based Purchasing
  - Identify discrete populations, and types that change
  - Provide objective outcomes for performance goals and incentives
- Providers should use communimetric data to protect themselves from risk sharing downsides
  - Ensuring they get populations that can meet outcomes expectations
- Payers can use communimetrics to ensure VBPs are improving quality and care

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Thank you!

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