

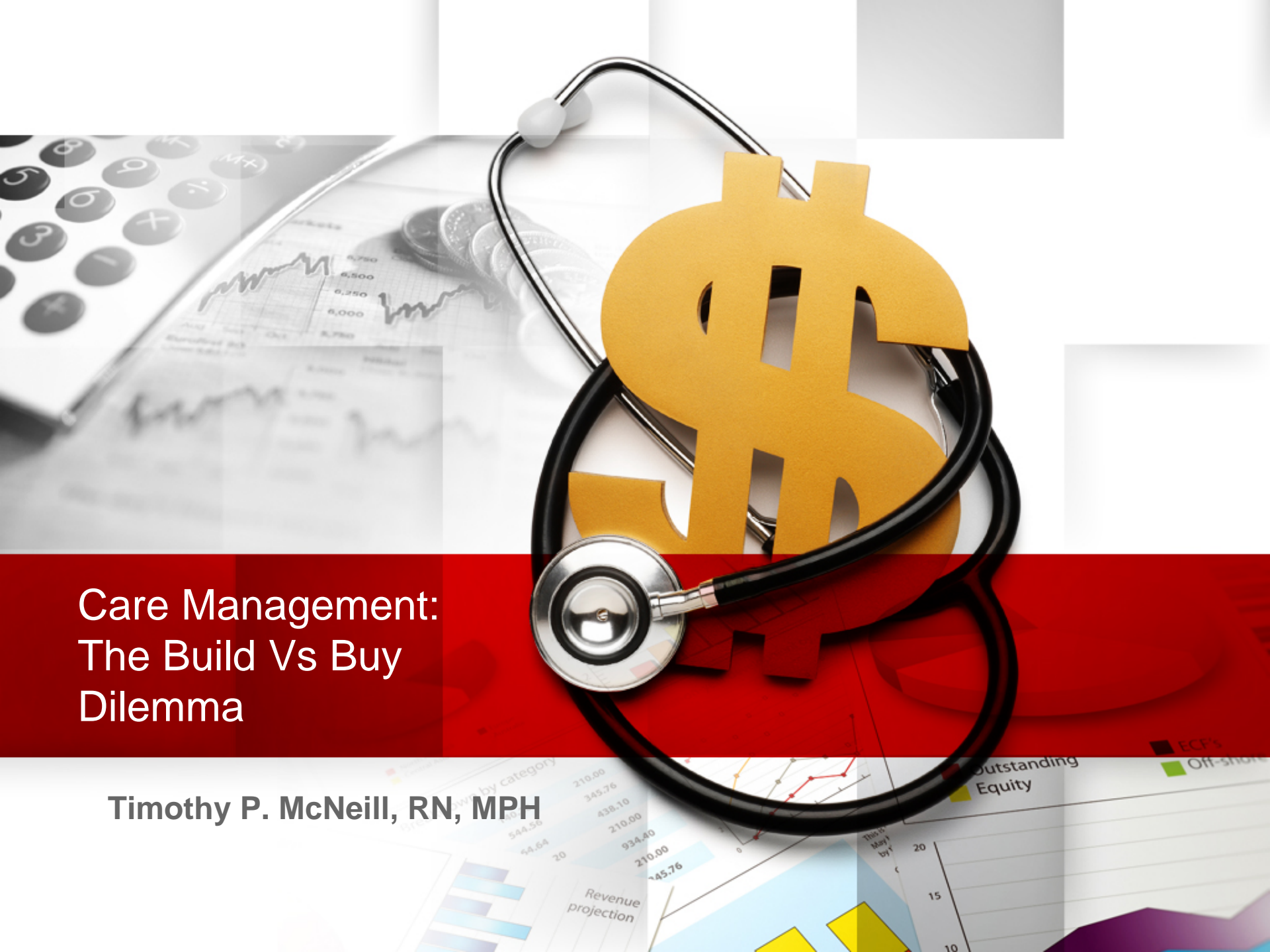


# Welcome to TIM Talks:

# Care Management – The Build vs Buy Discussion

## September 28, 2017





# Care Management: The Build Vs Buy Dilemma

Timothy P. McNeill, RN, MPH



1 Health Reform's Impact

2 Care Coordination Opportunities

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4 Negotiation Options for Build Vs Buy



# Shift Towards Value-Based Purchasing

- Reform Initiatives (ACA, MACRA) have pushed healthcare providers to adopt population health strategies to achieve improved health outcomes and reduced expenditures
- The shift towards value-based purchasing is putting increased emphasis on the role of care coordination
- Increasingly an investment in care coordination services is seen as essential to success in the health reform landscape



# Expected Growth in Care Coordination/Care Mgmt

- Organizations that are expanding care coordination efforts to achieve success in payment reform environment
  - Managed Care Organizations (MCOs)
  - Health Systems that want to reduce readmissions
  - Accountable Care Organizations (ACOs)
  - Patient-Centered Medical Homes (PCMHs)
    - Health System-Owned Physician Practices
    - Independent Medical Practices
  - Physician Groups participating in bundled payment



# Quality Measures

- Value-Based Purchasing requires improving costs and quality
  - MCOs
    - STAR Ratings
    - HEDIS
  - ACOs
    - ACO Quality Measures
  - Providers
    - MIPS



# The Build Vs Buy Proposition

- When tasked with addressing population health requirements healthcare executives often seek to control care coordination services.
- When faced with limited financial resources, organizations must decide:
  - Set up an internal team to provide care coordination services for high-risk populations (Build)
  - Purchase care coordination services from a third party (Buy)



# Why Did They Decide to “Build” it Themselves

- Potential Reasons Providers may choose the “Build” option
  - Desire to “control” the delivery of services to ensure that predictable outcomes are achieved
  - Stable budget line item with perceived cost savings obtained by building an internal team vs per person payment models
  - Lack of awareness of the ROI for buying services from CBO
  - Ability to rapidly assign resources based on perceived population health needs





# Key Decision Drivers

- Outcomes
  - Value-Based Payment models require achieving improved clinical outcomes for the population that have to be documented and proven
- Costs
  - Shared savings programs link success to cost savings and reduced utilization
- ROI
  - Is our investment in care coordination going to achieve reduced medical expenditures and improved outcomes that exceeds our startup costs



# Barriers to the Success with the Build Option

- Rapid acquisition and expansion of health system-owned practices limits the reach of facility-based care coordination models
- Difficulty in coordinating services outside of acute and ambulatory care centers (Post Acute providers)
- Lack of awareness of facility-based care coordination teams on how to access programs to address social and psycho-social needs



# External Factors that influence the Build Vs Buy decision timeline

- Adoption of Risk-Based contract models in the market
  - Accountable Care Organizations
  - Bundled Payment
- Implementation of value-based contracts with managed care organizations
- Competitor's adoption of alternative payment models
- Need of the primary care network to obtain support with Quality Payment Program requirements
  - MIPS reporting
  - APM reporting



# Negotiating When a Healthcare Partner Has Chosen the Build Option

- Build vs Buy should not be the only two options
  - Build, Buy, or Partner
  - Present the advantage of the Partner Strategy when faced with a Build Vs Buy decision maker
- Most organizations will want some level of internal resources providing care coordination services
- The Build Team may be limited in their ability to achieve success with ALL populations
  - Low-Income Populations
  - Minority Populations
  - Rural Populations



# Optimal Strategy: Partner is superior to Build or Buy

- Extends the reach of internal resources
- Leverages expertise that is not internal to the organization
- Linkages with community-based organizations can access critical community resources to address factors that impact health outcomes
- Ability to combine services to address all factors impacting outcomes:
  - Medical
  - Social
  - Psychosocial



# Getting to “Yes” in the Partner Discussion

- Trust: History and reputation of serving target populations
- Clinical Integration: Willingness to clinically integrate with healthcare provider sites
- Data tracking: Alignment of program model with risk factors impacting the Healthcare provider
- Risk Stratification: Ability to integrate program model with healthcare provider Awareness of risk in the market
  - Populations
  - Areas in the market with greater risk



# Clinical Integration Options

- The ability to integrate with the health system or MCO operations is critically important
  - Culture of the organization
  - Health IT integration
  - Bi-directional data sharing of outcomes
  - Alignment of organizational goals
- Consider embedded care coordinators
  - Reinforces the partnership and shows immediate value
  - Enhances the referral pattern
  - Build the costs of embedded staff into the financial model



# Implementation of a Partner model

- The ability to integrate with the health system or MCO operations is critically important
- Establish a method of risk stratification
- Target services based on population risks and capacity of the partners to reach the need
- Establish a mutually-agreed upon referral process
- Track clinical outcomes that align with value-based payment requirements
- Interact with internal care coordination leadership
- Continually reinforce the ROI





# Populations that are Impacting Population Health Goals

- Partner Model Care Coordination Programs should target populations that are most difficult for health systems and MCOs to address – based on Risk Stratification:
  - Multiple Chronic Conditions
  - Social Determinants of health
  - Dual-Eligible Status
  - Homebound Populations
  - Persons with a behavioral health co-morbidity
    - Ex. Chronic Depression + 2 or more chronic conditions



# Risk Stratification Strategy: Multiple Chronic Conditions

- Persons with multiple chronic conditions can benefit from care coordination programs that include:
- Health Coaching
- Disease Self-Management Education
- Patient Activation
- Support to improve
- Medication Adherence
- HCBS



CMS Medicare Chartbook:

# CHRONIC CONDITIONS

AMONG MEDICARE BENEFICIARIES

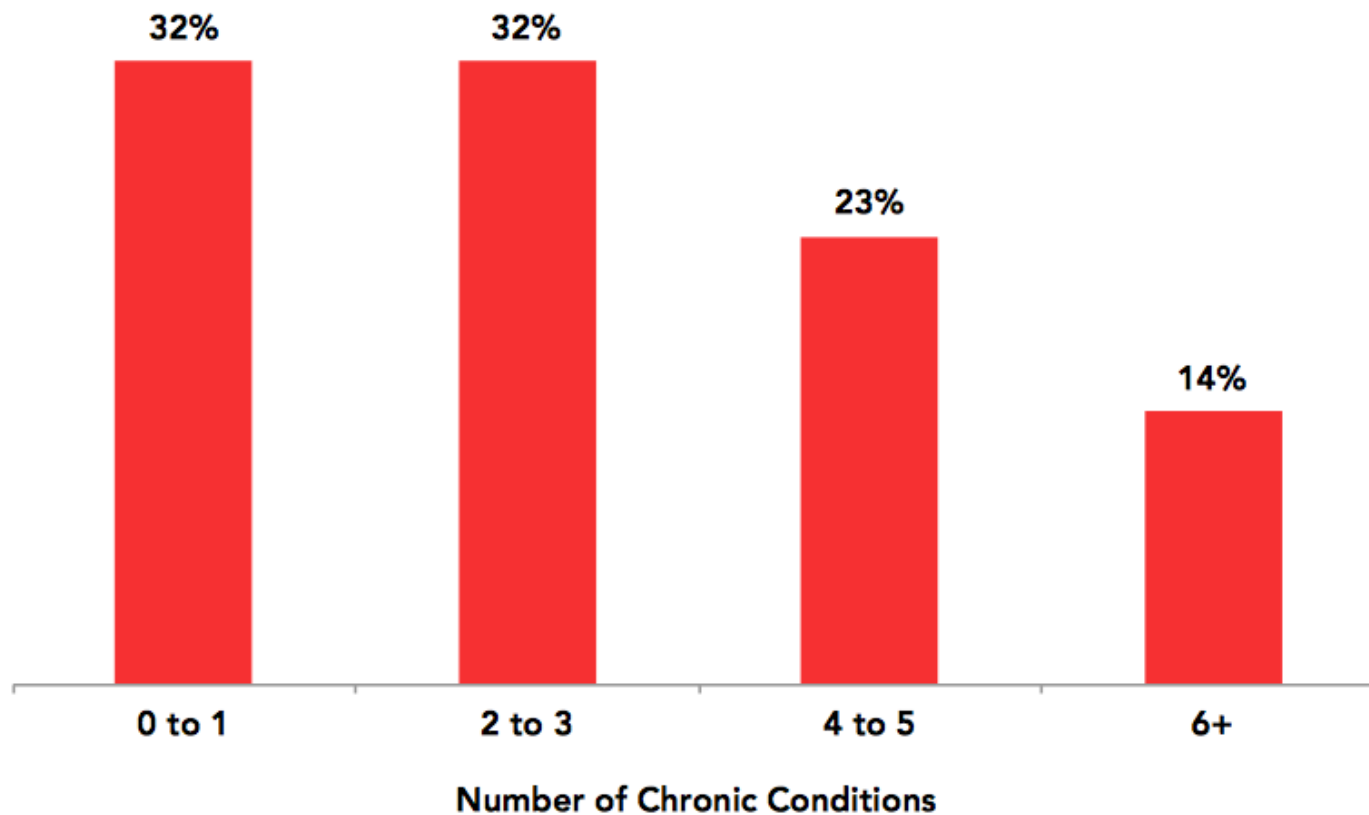


<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf>



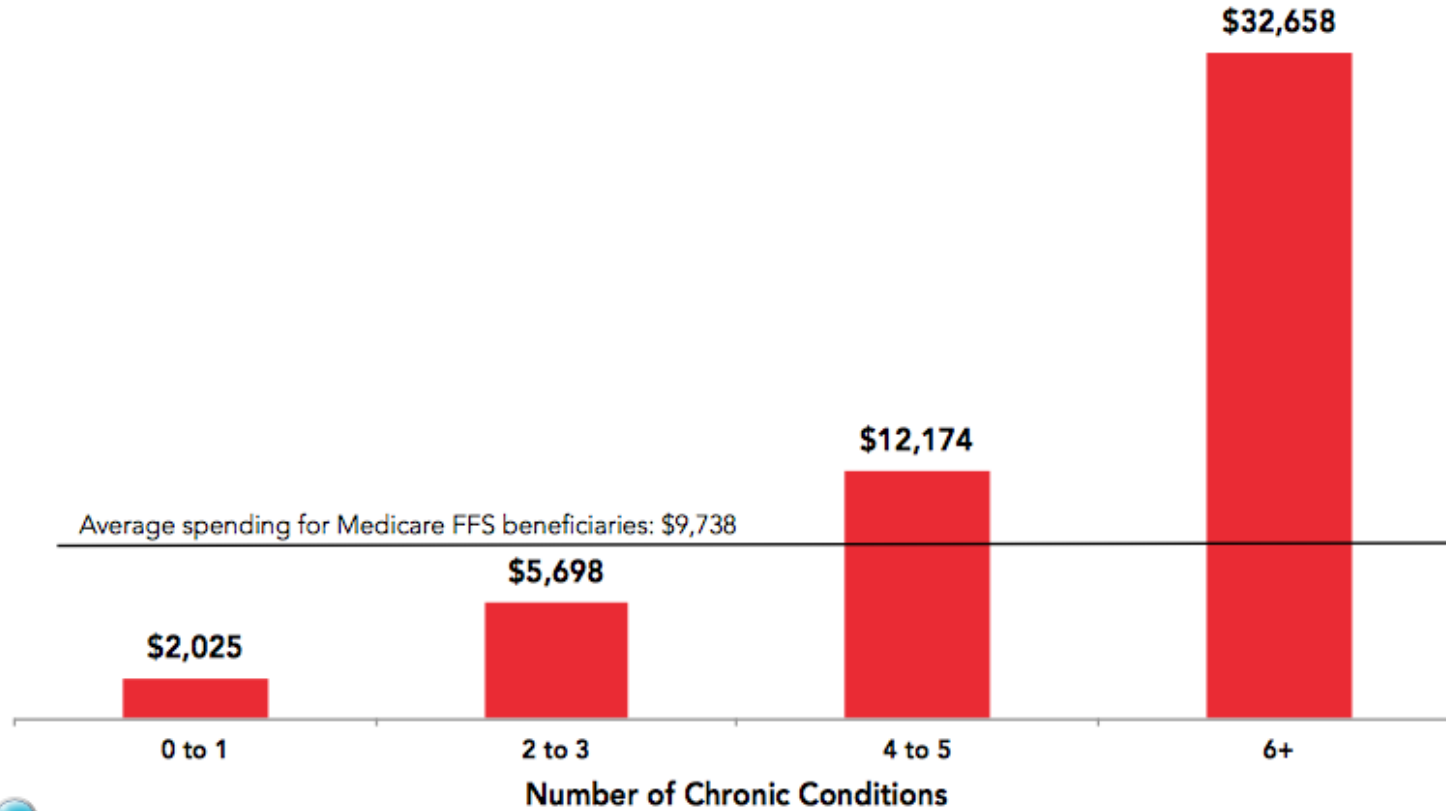
# Nearly 70% of FFS Medicare has 2 or more chronic conditions

**Figure 1.2a** Percentage of Medicare FFS Beneficiaries by Number of Chronic Conditions: 2010



# Per Capita Expenditures increase as the conditions increase

**Figure 3.1a** *Per Capita Medicare Spending for Medicare FFS Beneficiaries by Number of Chronic Conditions: 2010*



# Risk Stratification Strategy: Social Determinants of Health

- Low-Income Status has been proven to have a negative impact on achieving defined clinical outcome goals
- Populations impacted by social determinants of health need support to address social and psychosocial factors impacting health outcomes
- Successful interventions extend beyond the clinical setting and into the community



# CMS Analysis: Social Determinants of Medicare Advantage Plan Performance



## Examining the Potential Effects of Socioeconomic Factors on Star Ratings\*

*Center for Medicare*

September 8, 2015



\*The research presented is sponsored by CMS under contract HHSM-500-2013-00283G and performed by the RAND Corporation. The RAND Team included the work of Melony Sorbero, Ann Haas, Cheryl Damberg, Marc Elliott, and Susan Paddock.



# CMS Analysis: Social Determinants of Medicare Advantage Plan Performance

## Summary of Associations Between Performance and LIS/DE or Disability

| Type of Association             | LIS/DE | Disability |
|---------------------------------|--------|------------|
| Positive                        | 2      | 3          |
| No effect (not significant)     | 2      | 1          |
| Negative                        | 12     | 11         |
| <b>Total Number of Measures</b> | 16     | 15*        |

\* Readmissions is excluded as it is already adjusted for several factors that could determine Disability status.

The findings were somewhat mixed:

- Most associations were negative. This means that vulnerable beneficiaries were less likely than non-vulnerable beneficiaries to receive the recommended care or outcome.
- For a small subset of measures, the association was positive. In other words, vulnerable beneficiaries were more likely to receive the recommended care or outcome. There were more measures that demonstrated a positive association with Disability as compared to LIS/DE.





# CMS Analysis: Social Determinants of Medicare Advantage Plan Performance

## Likelihood of Receiving Recommended Care or Outcomes

| HEDIS Measure (MA Contracts)                        | LIS/DE Adjustment Odds Ratio | Disability Adjustment Odds Ratio |
|---|------------------------------|----------------------------------|
| Adult BMI Assessment                                | 1.11***                      | 0.93***                          |
| Rheumatoid Arthritis Management                     | 0.85***                      | 1.17***                          |
| Breast Cancer Screening                             | 0.69***                      | 0.72***                          |
| Controlling High Blood Pressure                     | 0.99                         | 1.02                             |
| Diabetes Care – Blood Sugar Controlled              | 0.68***                      | 0.63***                          |
| Diabetes Care – Eye Exam                            | 0.93***                      | 0.68***                          |
| Diabetes Care – Kidney Disease Monitoring           | 0.93***                      | 0.69***                          |
| Colorectal Cancer Screening                         | 0.87***                      | 0.47***                          |
| Osteoporosis Management in Women who had a Fracture | 0.71***                      | 0.56***                          |
| Plan All-Cause Readmissions <sup>#</sup>            | 0.87***                      | N/A <sup>&amp;</sup>             |
| Annual Flu Vaccine                                  | 0.85***                      | 0.72***                          |

**NOTE:** Separate analyses conducted for LIS/DE and Disability adjustment. Models control for between-contract differences.

<sup>#</sup> Measure is reverse-coded to make interpretation of Odds Ratio the same as other measures.

\* Significant at p<0.05 \*\* Significant at p<0.01 \*\*\* Significant at p<0.001

Blue Odds Ratio greater than 1.0 indicates a significant positive effect of being LIS/DE or Disabled.

Orange Odds Ratio less than 1.0 indicates a significant negative effect of being LIS/DE or Disabled.

Black Odds Ratio indicates no significant effect.

<sup>&</sup> Not further adjusted for Disability. Readmissions is adjusted for factors that might be part of a person's reason for Disability.



# Risk Stratification Strategy: Behavioral Health Co-Morbidity

- Multiple studies have shown that the presence of depression and social isolation correlate with significantly higher costs and poor clinical outcomes for persons with heart disease such as congestive heart failure.
- Depression in the older adult population is particularly difficult to identify and manage



# How to Prepare for a Build Vs Buy Negotiation?

- Research the customer to determine what risk they are facing and the demographics of the population in the risk model
  - STAR / HEDIS
  - ACO Measures / MIPS
  - Assess the performance of the healthcare provider in addressing risk of each segment of the population they serve
- Determine if there are current shared populations or target groups that we both serve
- Establish a risk stratification strategy and referral pattern



# Where Do We Start if “Partner” Option is Selected

- Determine how our teams achieve clinical integration
- Determine the best option for referral management and outcome reporting of clinical measures
- Establish mutually agreed upon program goals that align with value-based payment contract requirements
- Define how we will track ROI
  - Data tracking
  - Outcome measurement
  - Continually report on ROI analysis whenever possible



# ROI

- Critically Important to continually reinforce ROI
- ROI increases when linked to third-party reimbursement
- Strategies that support covering the cost of the program through enhanced reimbursement and collection.
- Budget Neutral options are preferred over programs that are fully funded by healthcare provider or health system
- A budget neutral option that can increase performance under value-based contracting exponentially increases ROI



# Pilot the Process

- Identify One Provider within the organization to test the process
  - Seek out a champion
  - Develop a model of sharing clinical data
  - Establish a process of targeting the participants
  - CBO and Provider gain knowledge of the culture of the business
  - Embed a health coach within the practice



# Tracking Performance: Establish Mutual Expectations

- Financial

- ROI
- Payer Source
  - MCO
  - Chronic Care Management Contract
  - Collaborative Care Management Contract
  - LTSS Waiver / MLTSS
- Number of enrolled clients
- Services provided per beneficiary per month

