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Q+A will open at the end of the presentation.

## **Follow-up questions?**

### **Contact**



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# UNDERSTANDING VALUE- BASED CARE & VALUE- BASED PURCHASING

**PRESENTED BY:**

**Caitlin Thomas-Henkel, MSW  
DaShawn Groves, DrPH, MPH**

**Thursday,  
November 3, 2022  
12:00 pm – 1:00 pm EST**

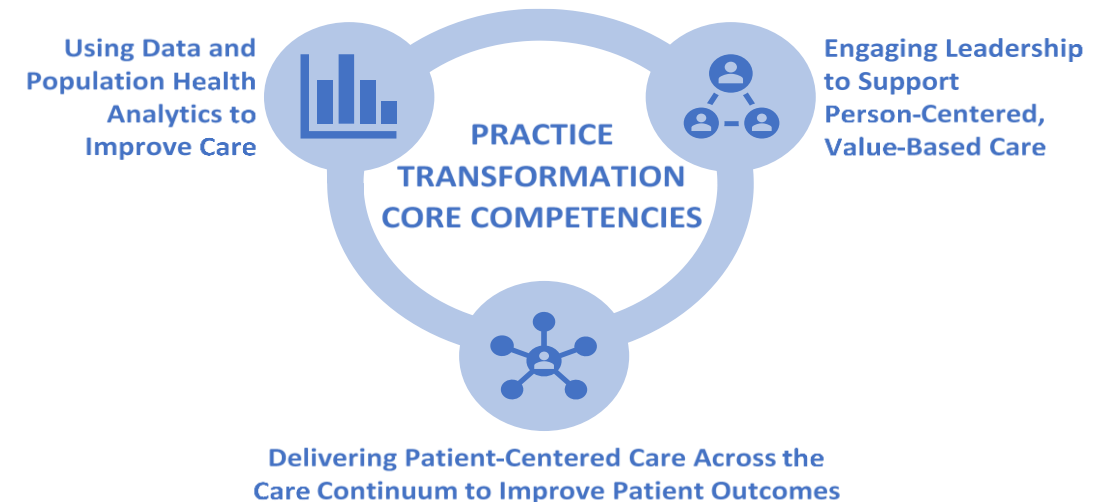
Integrated Care DC is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH). This project is supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling \$4,616,075.00 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, or an endorsement by, CMS/HHS, or the U.S. Government.

# WHAT IS INTEGRATED CARE DC?



- >> Integrated Care DC is a five-year program aimed to enhance Medicaid providers' capacity and core competencies to deliver whole person care for physical, behavioral health, SUD and social needs of beneficiaries.
- >> Integrated Care DC is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH). Health Management Associates will provide the training and technical assistance.

The goal is to improve care and Medicaid beneficiary outcomes within three practice transformation core competencies:



- » The program offers several components of coaching and training. Material is presented in various formats. The content is created and delivered by HMA subject matter experts with provider spotlights.
- » All material is available on the project website: [Integratedcaredc.com](https://integratedcaredc.com)
- » Educational credit is offered at no cost to attendees for select elements.



## >> Are you receiving our Integrated Care DC Newsletters?

**Check your inbox** at the beginning of the month for the Monthly Newsletter and around the 15th for the Mid-Month Update.



## >> Got ideas?

**Take this short survey** to share suggestions and requests for trainings.

<https://www.integratedcaredc.com/survey/>



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<b>Company</b>	No financial disclosures	No financial disclosures	No financial disclosures	No financial disclosures
<b>Nature of relationship</b>	N/A	N/A	N/A	N/A

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- ❖ Health Management Associates, #1780, is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved as ACE providers. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. Health Management Associates maintains responsibility for this course. ACE provider approval period: 09/22/2022 – 09/22/2025. Social workers completing this course receive 1.0 continuing education credits.

To earn CE credit, social workers must log in at the scheduled time, attend the entire course and complete an online course evaluation. To verify your attendance, please be sure to log in from an individual account and link your participant ID to your audio.

- ❖ The AAFP has reviewed Integrated Care DC Webinar Series and deemed it acceptable for AAFP credit. Term of approval is from 02/08/2022 to 02/07/2023. Physicians should claim only the credit commensurate with the extent of their participation in the activity. This session is approved for 1.0 Online Only, Live AAFP Prescribed credits.
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- ❖ Certificates of completion will be emailed within 10-12 business days of course completion.

## The Foundations of Value Based Care & Value Based Purchasing

- » Welcome and Program Announcements
- » National Trends and Data
- » DC Strategy Overview
- » Foundational concepts of integrated, value-based care/performance
- » LAN/APM Frameworks
- » Closing Remarks/Q&A



# OBJECTIVES

1. Describe national trends and the District's goals for transitioning to VBP
2. Identify the foundational concepts of integrated, value-based care/performance.
3. Articulate the foundational Learning and Action Network (LAN) alternative payment methodology (APM) framework



Image permitted by DC Department of Health Care Finance

# WHAT IS DRIVING THE VALUE-BASED PERFORMANCE CONVERSATION?

- >> Approximately 1 in 5 adults aged 65 or older in the US has a diagnosed mental health condition
- >> Over 2.5 million youth in the U.S. have severe depression, and multiracial youth are at greatest risk.
- >> 20 million Americans have a Substance Use Disorder
- >> Over half of adults with a mental illness do not receive treatment, totaling over 27 million adults in the U.S. who are going untreated.
- >> Suicidal ideation continues to increase among adults in the U.S.
- >> More than a third (37%) of high school students reported they experienced poor mental health during the COVID-19 pandemic, and 44% reported they persistently felt sad or hopeless during the past year

Sources: <https://mhanational.org/issues/state-mental-health-america>

<https://www.cdc.gov/media/releases/2022/p0331-youth-mental-health-covid-19.html>

- >> Only 20% of children who need services receive care It's better for youth enrolled in Medicaid or CHIP, but still only 54% of non-institutionalized kids who need MH care receive it...)
- >> 65% of adults who have a serious mental illness receive mental health services
- >> Disparities are significant:
  - 50% of Latinx and 58.2% of Black African American young adults ages 18-25 who have a serious mental illness may not receive treatment
  - 90% of Black and African Americans with a substance use disorder do not receive care

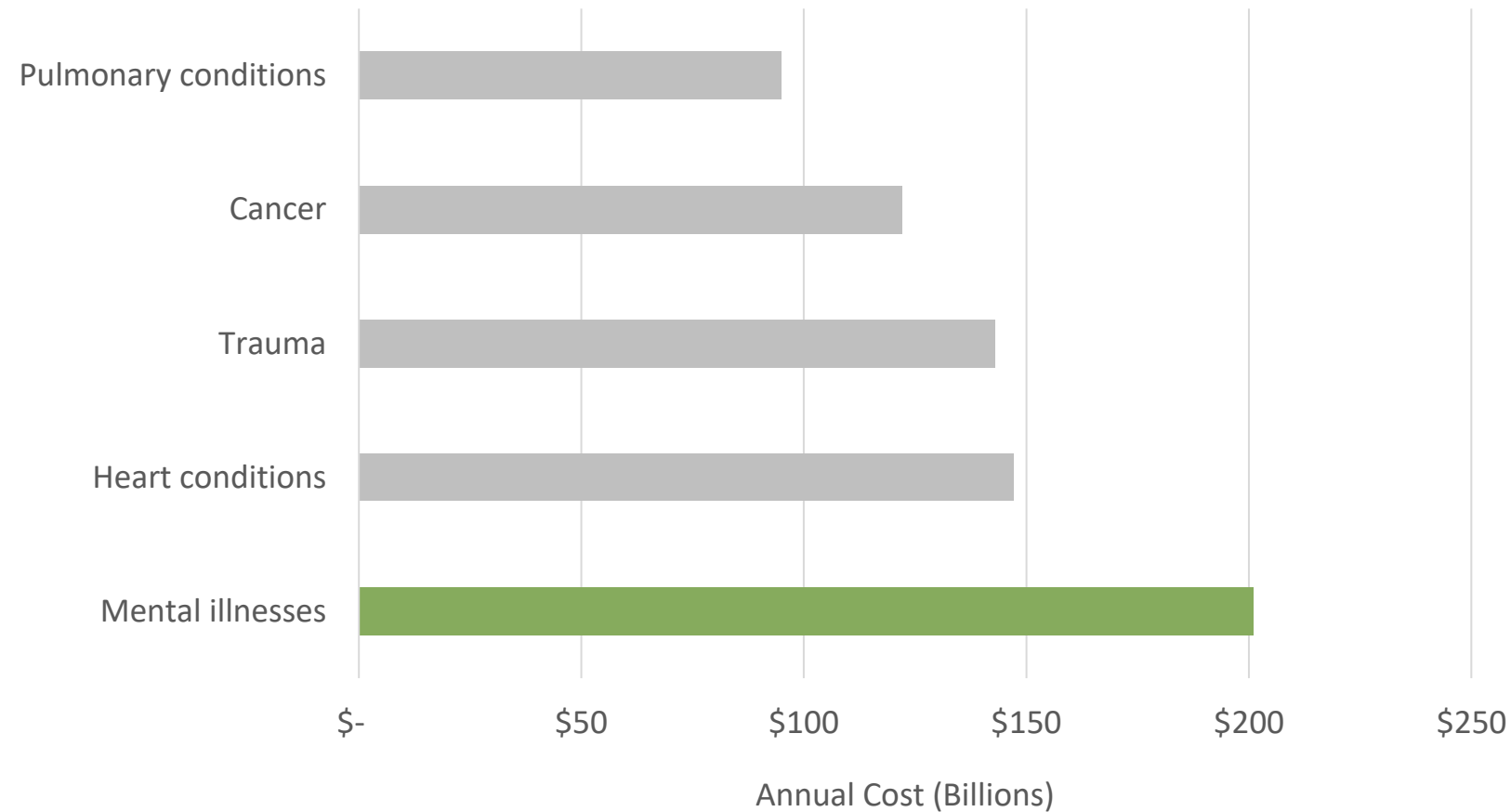
Sources: <https://mhanational.org/issues/state-mental-health-america>

<https://www.cdc.gov/media/releases/2022/p0331-youth-mental-health-covid-19.html>

# THE ASSOCIATION BETWEEN PHYSICAL AND MENTAL HEALTH



# MENTAL DISORDERS ARE THE MOST COSTLY CONDITIONS IN THE US

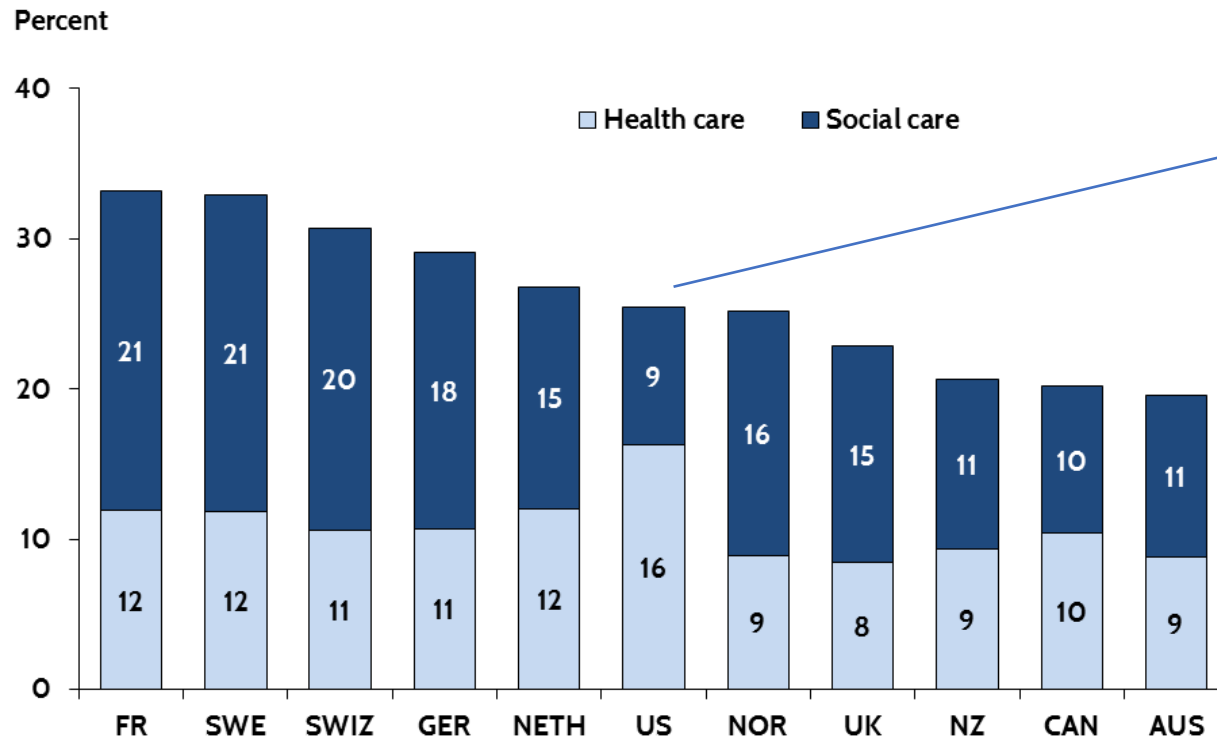


Source: Roehrig C, Mental Disorders Top The List Of The Most Costly Conditions In The United States: \$201 Billion. Health Affairs 35, no. 6 (2016) 1130 – 1135.  
JAMA Association of Mental Health Disorders With Health Care Spending in the Medicare Population  
<https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2762948>

# WHAT DETERMINES HEALTH?

>> Not health care spending...

**Exhibit 8. Health and Social Care Spending as a Percentage of GDP**



**US: 64% of total % spent on health;  
36% on social care.**

US medical spending is higher, but our life expectancy and infant mortality rates are far lower...if (when?) we balance human services to comparable levels, there would (will?) be \$1.19 trillion more spent in human services.

Notes: GDP refers to gross domestic product.

Source: E. H. Bradley and L. A. Taylor, *The American Health Care Paradox: Why Spending More Is Getting Us Less*, Public Affairs, 2013.

1. What statistic were you:
  - Most surprised by?
  - Not surprised by?
  - Wondered about?
  
2. What are your thoughts about what impacts health outcomes?





**Department of Health Care Finance (DHCF) is a cabinet-level agency responsible for the administration of Medicaid and other public health insurance programs in DC**

## **VISION**

All residents in the District of Columbia have the supports and services they need to be actively engaged in their health and to thrive.

## **MISSION**

The Department of Health Care Finance works to improve health outcomes by providing access to comprehensive, cost-effective and quality healthcare services for residents of the District of Columbia.

## **VALUES**

Accountability – Compassion – Empathy – Professionalism – Teamwork

# BUILDING ON DELIVERY SYSTEM CHANGES AND INFRASTRUCTURE IMPROVEMENTS, DHCF ANNOUNCED MEDICAID REFORM EFFORTS IN 2019



**Coverage:** Leveraged ACA opportunities to expand coverage to low-income adults

**Knowledge Building/Performance:** Created data warehouse to expand quality measurement and data analysis through the Medicaid Data Warehouse

**IT:** Developed technology infrastructure to allow for secure exchange of information across providers through HIE, EHR

**Value:** Increasing value-based payment approaches through pay for performance models in:

- Managed care program
- FQHC Alternative Payment Methodology
- Other provider reimbursement / payment methods

**Enhanced Care Coordination:** Promoting access to the right care at the right time through health homes program

## Strategic Priorities to Guide Reform Efforts

1. Building a health system that provides whole person care
2. Ensuring value and accountability
3. Strengthening internal operational infrastructure
4. Unwinding from the public health emergency (PHE)

## State Innovation Model Design Grant

- >> Stakeholder Engagement Activities from September 2015 to July 2016
- >> Activities included
  - Five topic-specific work groups
    - (Care Delivery, Payment Models, Community Linkages, Quality, & HIE)

## >> **Care Delivery Transformation**

- >> Put the patient first and meet the patients where they are
- >> Deliver the right care, right time, right place, right cost
- >> Address social determinants of health
- >> Foster team-based care
- >> Align across all providers (e.g. housing entities, behavioral health, etc.)
- >> Include effective transitions of care, resourced at the provider level
- >> Promote evidence-based interventions and use of technology
- >> Develop more integrated system(s) that aim to eliminate disparities and reduce inappropriate utilization of services

## >> **Payment Transformation**

- >> Align financial incentives with health system goals (e.g. shared accountability)
- >> Ensure performance measures are appropriate of population and care setting
- >> Not all providers will be ready to take on risk, allow for a menu of payment options to promote value
- >> Payment transformation should be incremental, yet purposeful
- >> Ensure a robust threshold for attribution methodology and engage stakeholders

## >> **Infrastructure/ Resources to Support Care Delivery Transformation**

- >> Share information that is accurate, actionable and accessible
- >> Leverage existing strategies/resources
- >> Make upfront investments to providers
- >> Provide technical assistance on practice transformation and HIT/HIE

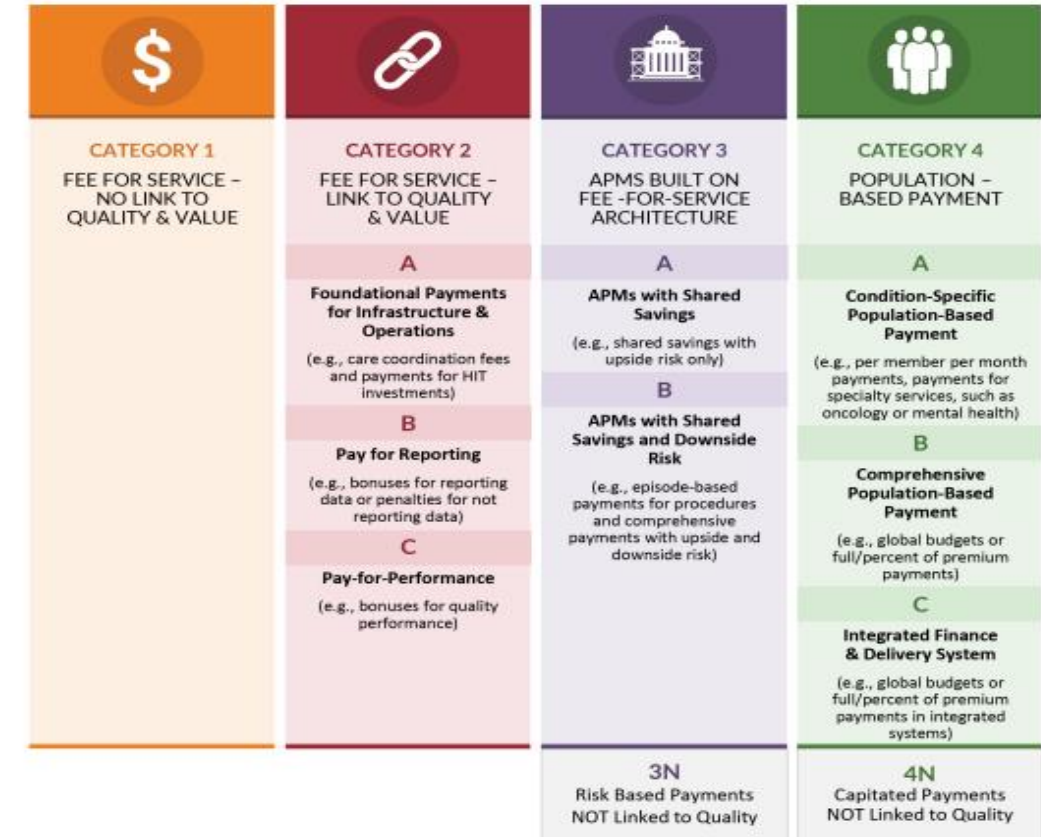
- >> The purpose of the Commission is to make recommendations to the Mayor on the strategies and investments necessary to transform health care delivery in the District of Columbia.
- >> The Commission's work shall focus on developing recommendations that address the current stresses in the District's health care system, focused on:
  - >> improving access to primary, acute, and specialty care services, including behavioral health care;
  - >> addressing health system capacity issues for inpatient, outpatient, pre-hospital and emergency room services; and
  - >> promoting an equitable geographic distribution of acute care and specialty services in communities east of the Anacostia River.
- >> Subcommittee on Value-Based Purchasing of Health Care Services had four recommendations
  - >> Engage the community for the road ahead
  - >> Expand quality measurement to capture more data on health system effectiveness and to inform care delivery, payment incentives and population
  - >> Make key investments and policy changes to promote system integration for accountable care transformation
  - >> Align payments with value-based care goals to move towards a risk-based model encouraging coordination and health promotion

# DHCF USE HEALTH CARE PAYMENT LEARNING & ACTION NETWORK FOR DEVELOPMENT OF VALUE-BASED PAYMENT



## >> What is the Health Care Payment Learning & Action Network?

Since 2015, The Health Care Payment Learning & Action Network (HCPLAN or LAN) is an active group of public and private health care leaders dedicated to providing thought leadership, strategic direction, and ongoing support to accelerate our care system's adoption of alternative payment models (APMs).



# DHCF IS IN THE PROCESS OF DEVELOPING A VBP ROADMAP GOALS



## » Clear and cohesive vision for Value Based Payment

- Externally, helps stakeholders to see clear system vision and understand how they fit together
- Internally, holds ourselves accountable to ensuring system elements fit together to realize stated VBP goals, and ensures collective understanding of system goals across divisions

## » Brings together disparate and complex program elements into a single place

- Effective for providing guidance and wayfinding to technical resources

## » Allows for the clear articulation of cross-cutting equity and social needs goals (as well as system gaps)

- Accountability for including equity and social needs as a foundation for realizing VBP goals

## » Provides a pathway for operationalizing strategic vision through managed care and FFS

- Links strategic imperatives with contract language and requirements to guide care deliver
- Outlines our expectations of what is needed from them (i.e. EHR, HIE connectivity, practice transformation) to include in rate setting but build into MCO guidance

1. Introduction
2. Past Efforts and Lessons Learned
  - a. Transformation Initiatives
3. VBP Contracting Requirements
4. Priority Populations
  - a. Maternal and Perinatal Health
  - b. Social Needs
  - c. Chronic Conditions
  - d. Behavioral Health
5. VBP Implementation Guidelines
  - a. VBP Model Examples
  - b. Attribution
  - c. Measures
  - d. Meaningful Upside and Downside Risk
6. Tools and Resources



VALUE

### >> Value-Based Payment

- Purchasers and payers of health care hold the health care delivery system accountable for both quality and cost of care
- Share both the risk and the reward of reducing the overall costs while achieving quality outcomes

### >> Value-Based Care

- Delivering services in ways that most create value for the people we serve and our society
- Attempts to reduce inappropriate care and to identify and reward the best performing providers

- » Value-Based payments (VBP) is an emerging type of payment approach that:
  - Pays for value
    - Better care
    - Better outcomes
    - Reduced costs
  - Instead of paying for volume
    - Visits
    - Procedures
- » VBP will increasingly become the dominant payment method for health care providers, including from Medicare, Medicaid, and commercial payers

## >> What are states and health plans buying?

- ✓ Better health and well-being
- ✓ Better experience of care for individuals and families served
- ✓ Bending the cost curve

## >> What is needed to perform in a way that achieves what states and health plans are buying?

- ✓ VBP Core Organizational Competencies

# CORE ORGANIZATIONAL COMPETENCIES TO FULFILL WHAT IS GOING TO BE EXPECTED IN THE FUTURE



**Population Health  
Planning**

**Model of Care and  
Practices to Achieve  
Outcomes**

**Technology**

**Operational Supports**

**Incentive-based  
contracts**

**Organizational Engagement**

These ***Core Organizational Strategies*** are often known as population health strategies or value-based performance strategies.

- >> At the heart of VBP is the value proposition
- Quality
  - Cost management
  - Capacity for volume and growth



Courtesy of Unsplash

# KEY VBP CONCEPTS/COMPONENTS: TYPES OF RISK



Shared savings: A portion of the savings achieved due to reducing costs against defined benchmarks



**Upside risk-only** payments models do *not* include any financial risk to providers if they do not achieve savings



**Downside risk payments** models do include financial risk to providers if they do not achieve savings



Shared savings payment models can include both or a transition from upside to downside risk

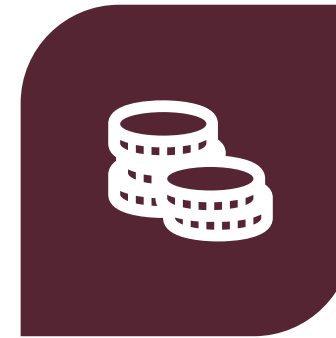
# KEY VBP CONCEPTS/COMPONENTS: TYPES OF PAYMENTS



**FEE-FOR-SERVICE:** PAYMENT  
BASED ON THE VOLUME OF  
SERVICES (E.G., SERVICES,  
VISITS, PROCEDURES)



**CARE MANAGEMENT FEE:** AN  
UPFRONT FEE PAID ON A PER  
MEMBER PER MONTH BASIS  
FOR DEFINED CARE  
MANAGEMENT SERVICES FOR  
A DEFINED POPULATION



**QUALITY INCENTIVE  
PAYMENTS:** PAYMENT FOR  
ACHIEVING DEFINED QUALITY  
METRICS



# KEY VBP CONCEPTS/COMPONENTS: TYPES OF PAYMENTS



**Partial capitation:** Payment where only certain types or categories of services are paid a specified amount per patient to deliver the services over a set period of time.



**Global payments/budgets:**  
Payment of a specified amount per patient to deliver all services over a set period of time.

Usually determined and paid on a per member per month (PMPM) basis

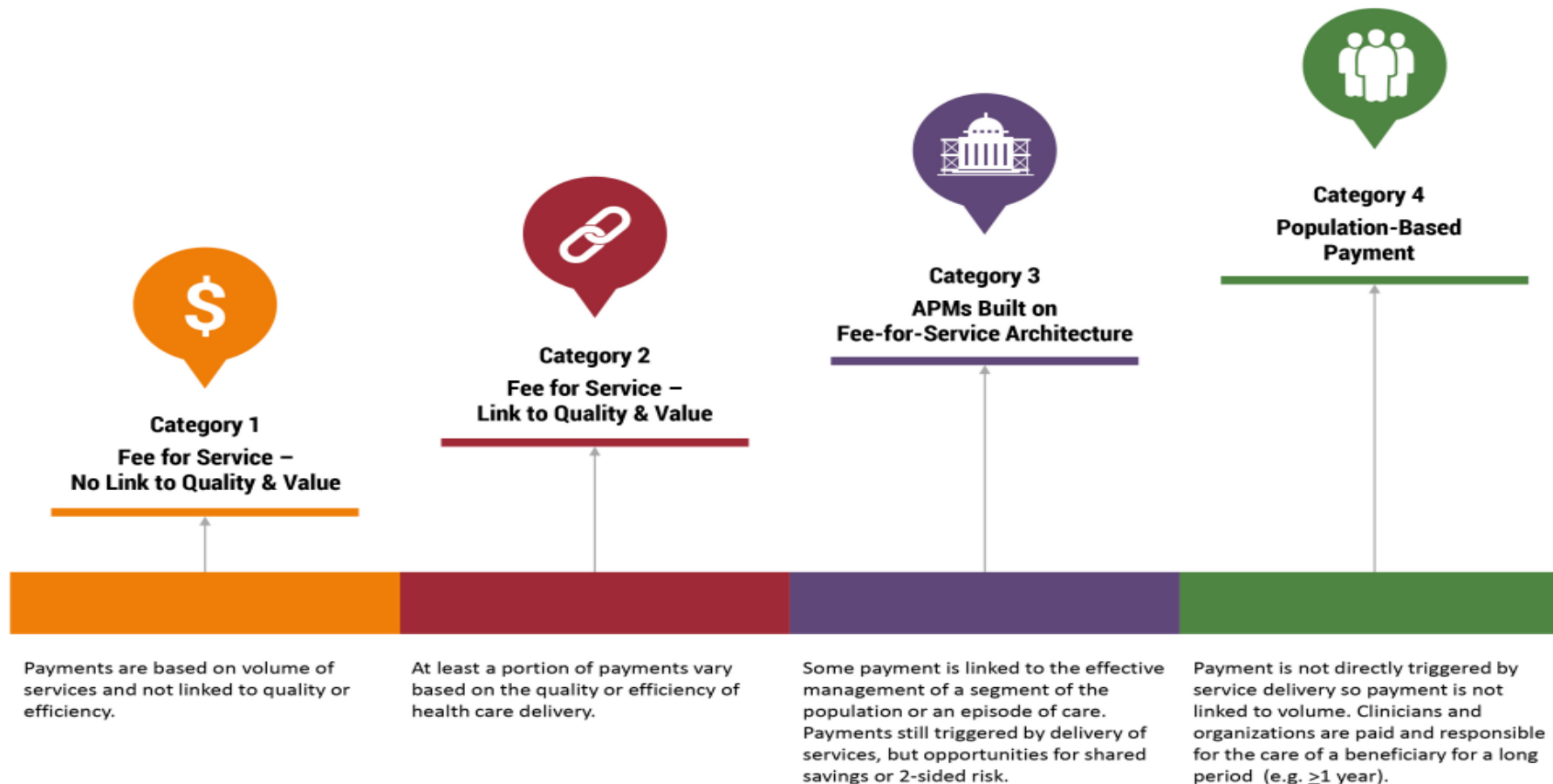
» Typically, value-based payments are a mix of different types of payment that incentives different things



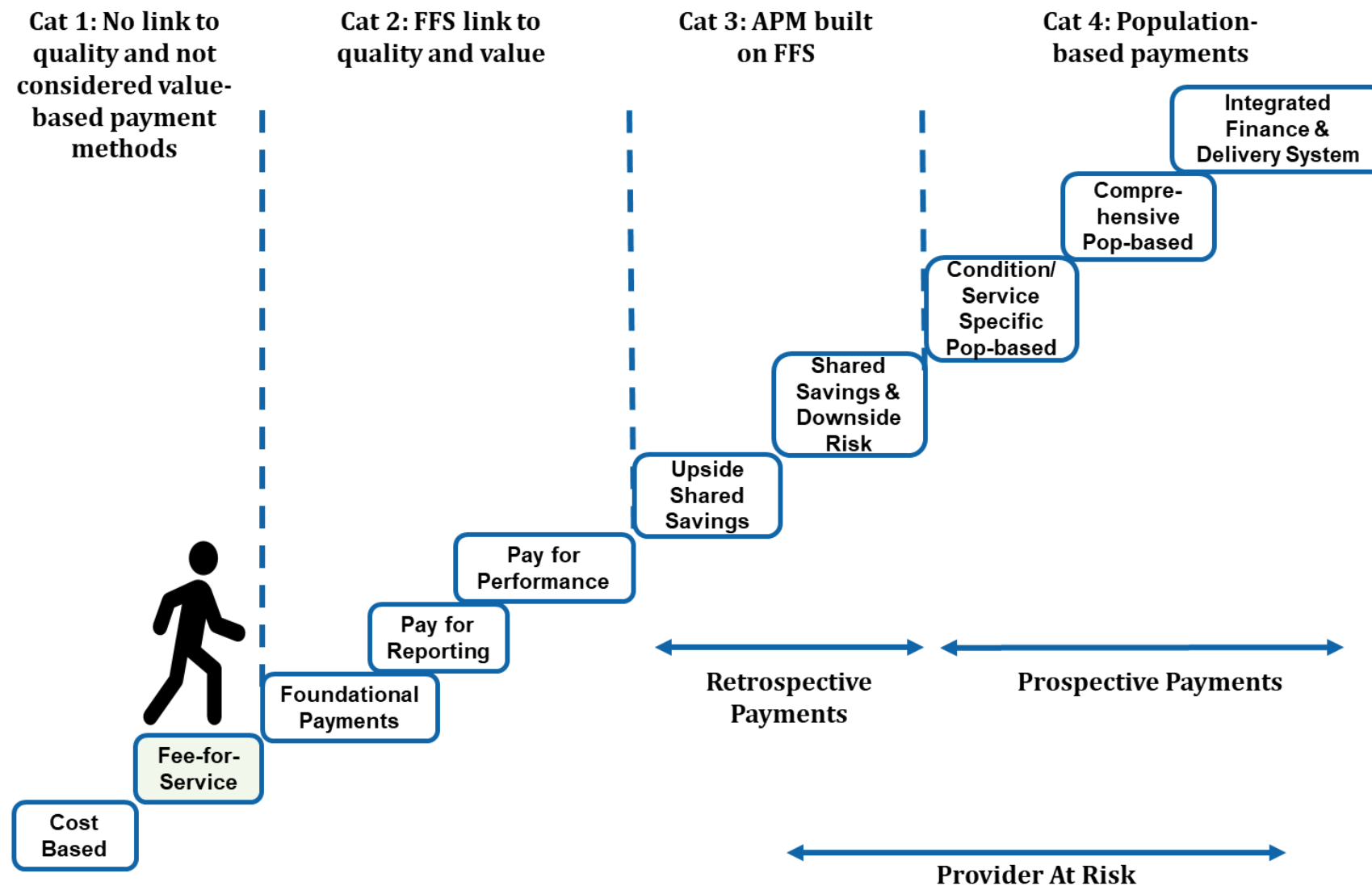
## >> What types of payment do you currently receive?

- Fee for service
- Care management fee
- Quality incentive payments
- Partial capitation
- Global payments
- I am unsure

## Health Care Payment Learning and Action Network Alternative Payment Model Framework

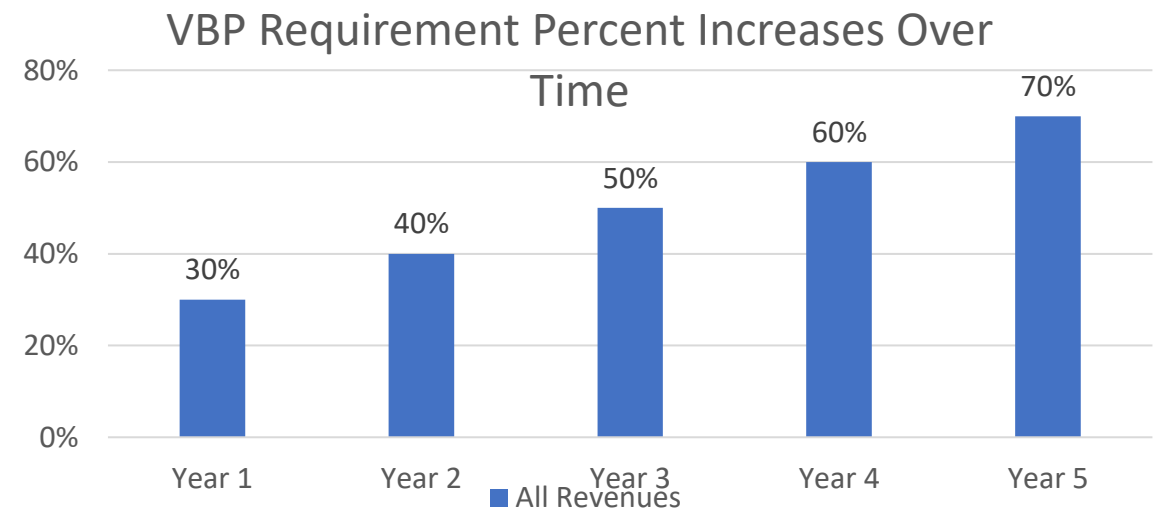
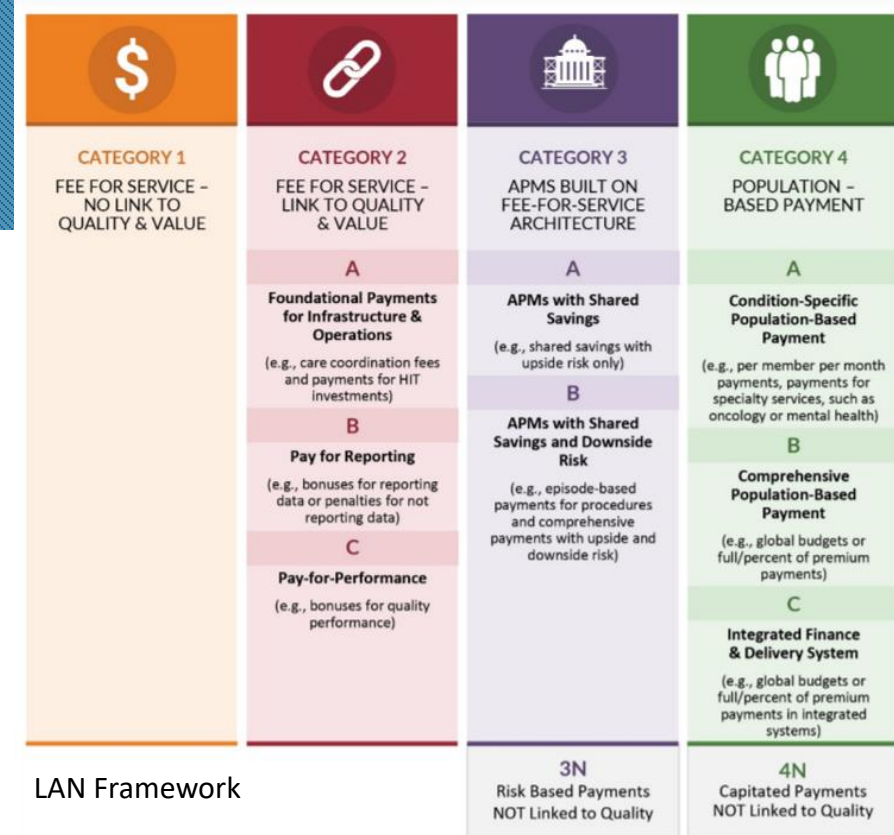


# ALTERNATIVE PAYMENT MODEL PROGRESSION

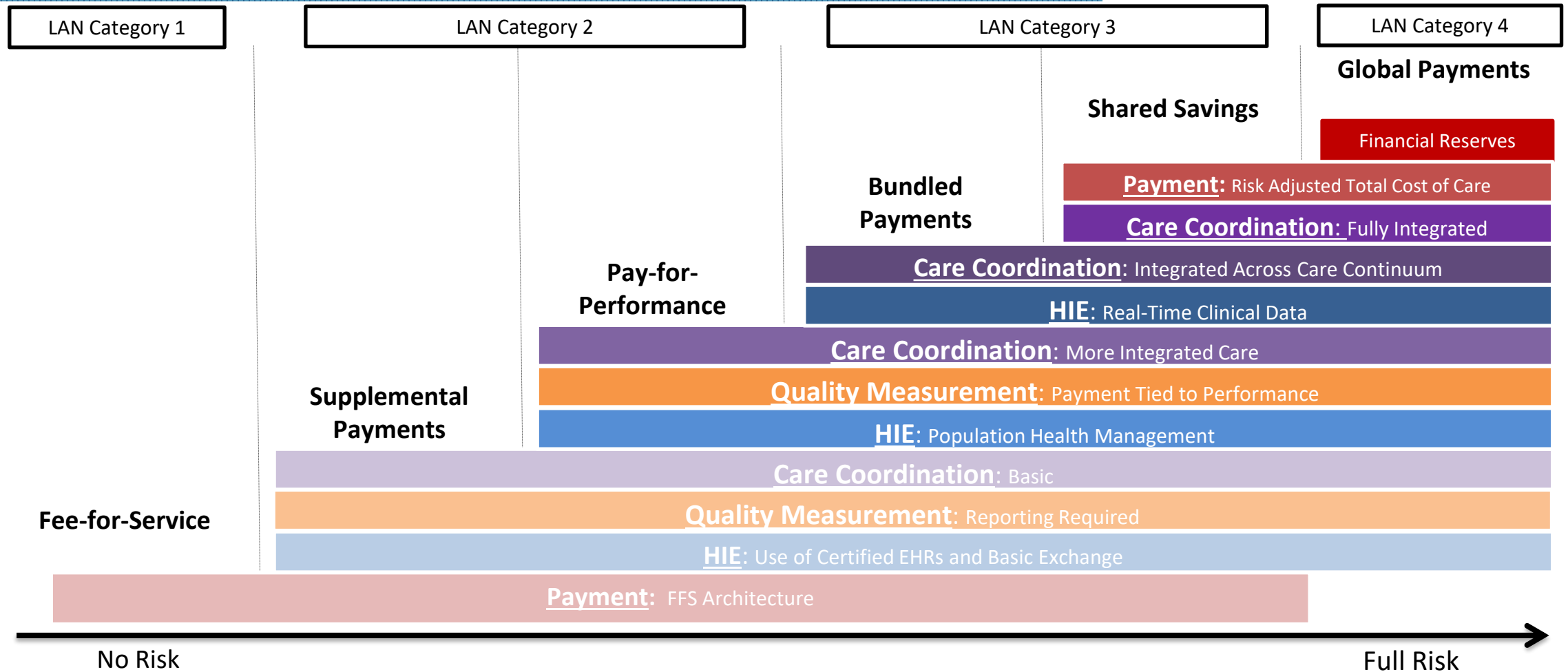


# MCO CONTRACTS PROVIDE GUIDANCE ON VBP TO MOVE THE NEEDLE

- » Base Year One: **30% of total** medical expenditures through VBP arrangements
  - All qualifying expenditures can be through models in LAN categories 2-4
- » Base Year Two: **40% of total** medical expenditures through VBP arrangements
  - All qualifying expenditures can be through models in LAN categories 2-4
- » Base Year Three: **50% of total** medical expenditures through VBP arrangements
  - At least half of qualifying total medical expenditures must be through models in LAN categories 3-4
- » Base Year Four: **60% of total** medical expenditures through VBP arrangements
  - At least half of qualifying total medical expenditures must be through models in LAN categories 3-4
- » Base Year Five: **70% of total** medical expenditures through VBP arrangements
  - At least half of qualifying total medical expenditures must be through models in LAN categories 3-4



# DHCF APPROACH TO VALUE BASED PAYMENT



\* Alternative Payment Model (APM) categories are based on the [2017 Update to the Health Care Payment Learning and Action Network Framework](https://www.springer.com/us/book/9783319969046). (LAN). In essence, category 1 is fee for service (FFS) with no link to quality; category 2 is FFS with a link to quality such as pay for reporting or a bonus payment for quality outcomes; category 3 is an an APM built on a fee for service architecture (e.g. shared savings, or shared savings with downside risk; and category 4 is population-based payment for populations or conditions.

Source: Edmunds, Hass, Holve (eds.), *Consumer Informatics and Digital Health*  
<https://www.springer.com/us/book/9783319969046>

# Q&A



## CONTACT US



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- >> *The State of Mental Health in America*. Mental Health America. (n.d.). Retrieved October 26, 2022, from <https://mhanational.org/issues/state-mental-health-america>
- >> Centers for Disease Control and Prevention. (2022, March 31). *New CDC data illuminate youth mental health threats during the COVID-19 pandemic*. Centers for Disease Control and Prevention. Retrieved October 26, 2022, from <https://www.cdc.gov/media/releases/2022/p0331-youth-mental-health-covid-19.html>
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- >> The webinar recording will be available within a few days at:  
<https://www.integratedcaredc.com/learning/>
  
- >> **Upcoming Webinar:**
  - *Part 2: Achieving Better Outcomes Through Value-Based Care and Population Health Strategies*, December 6, 12:00pm-1:00pm EST
  
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