A Decade of Clinically Integrated Networks in the Health Care Safety Net

The Delta Center
for a Thriving Safety Net

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Welcome & Introductions

Who We Are

Starling Advisors works nationally with Health Centers, Foundations, Networks, and PCAs to answer the question:

"What changes, if any, do we need to ensure Health Centers are successful in providing high-quality, comprehensive primary care under value-based systems?"

Small Team, Big Reach: Impacting Health Centers in over 35 States

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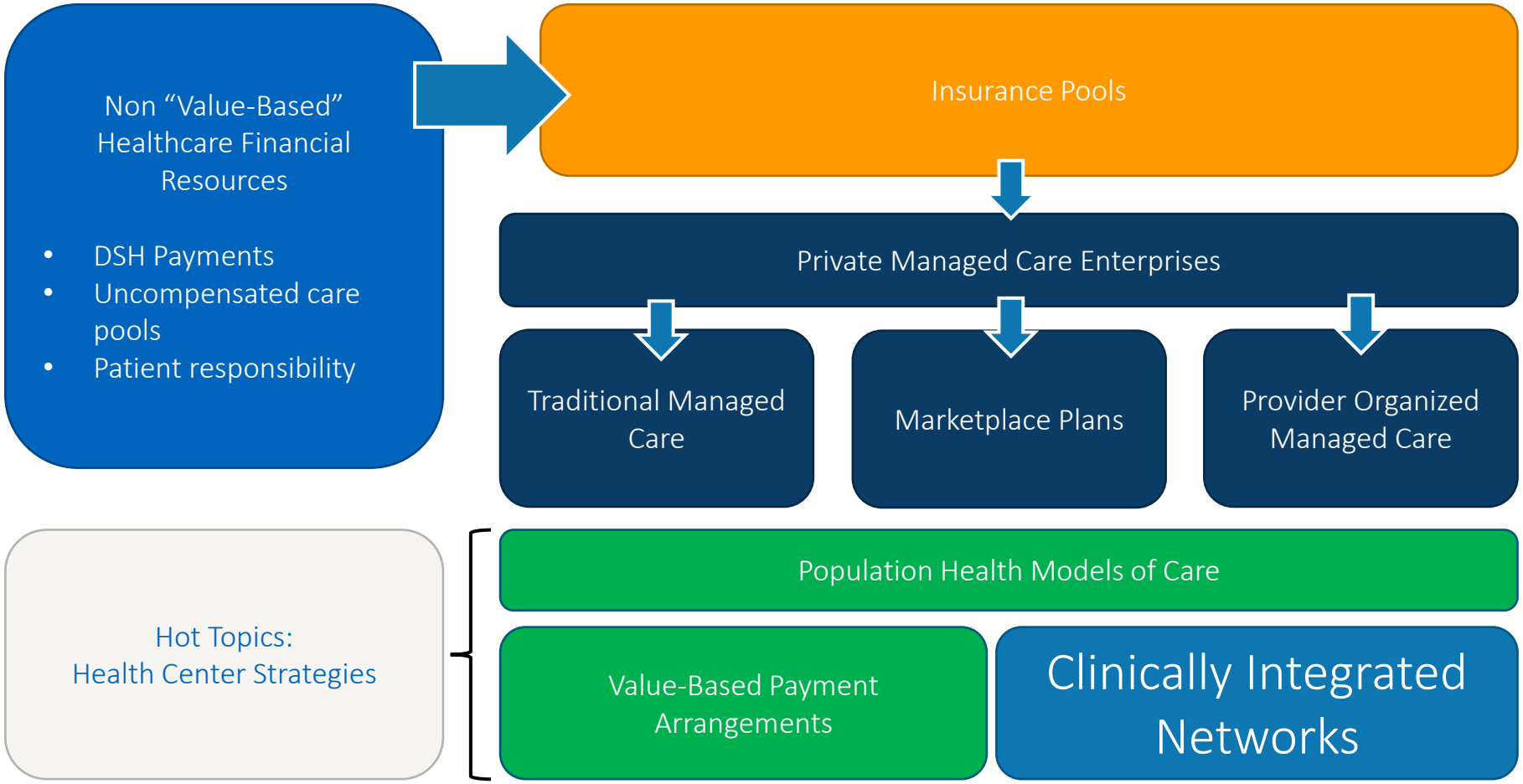
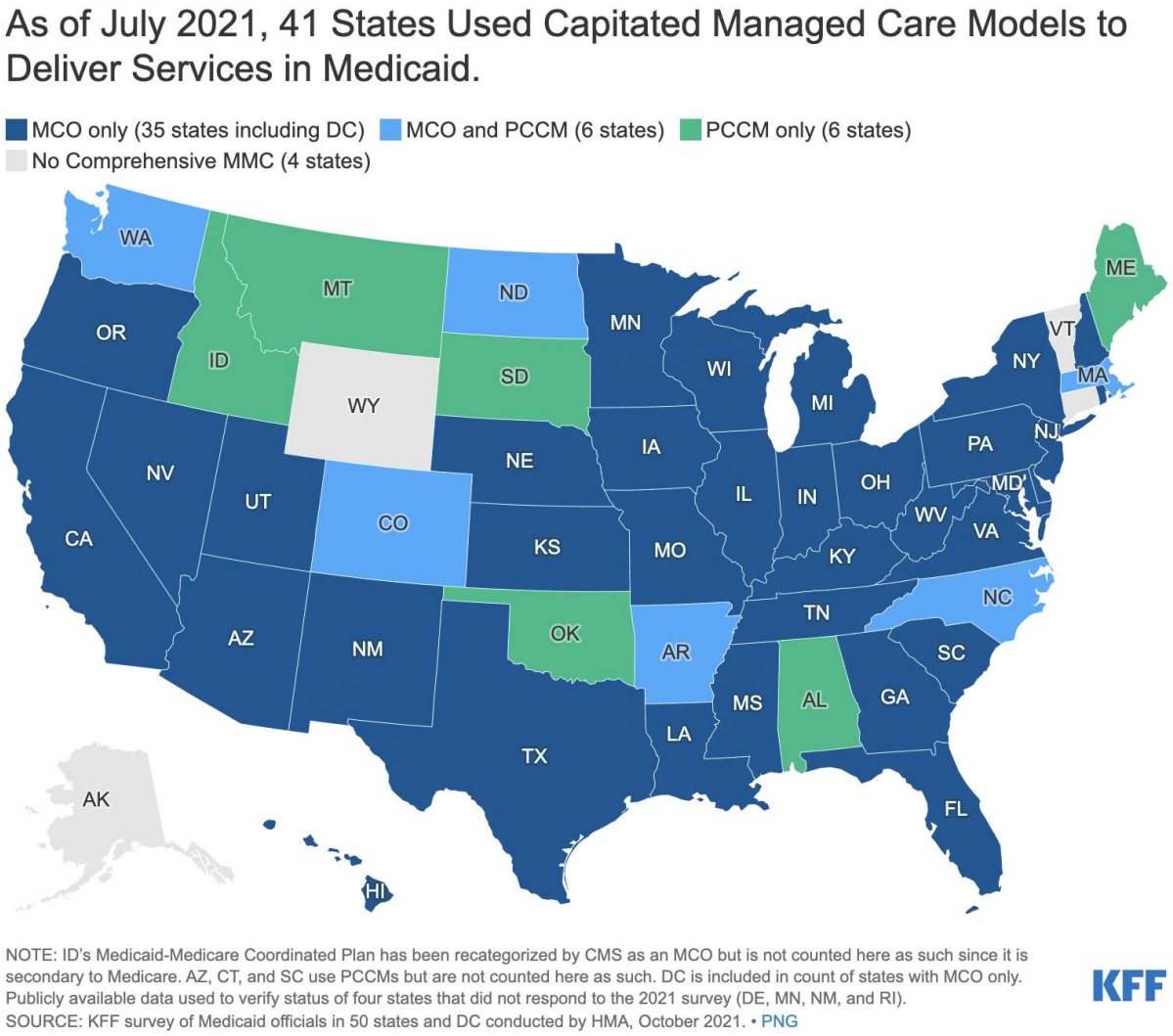
In 2010, the ACA disrupted the healthcare payment universe *(AKA a "Very Old Slide")*



Brief History of Network Trends / Activity

2010	• The Affordable Care Act is passed
2011	• Beginning of rapid rise of private Medicaid Managed Care • Health Centers participate in “Joint Ventures” to develop MCOs • First Medicaid ACO programs created in Colorado and New Jersey
2012	• Oregon adds CCO / Minnesota adds Medicaid ACO • First performance year for the Medicare ACO MSSP
2013	• First “new era” Health Centers IPAs begin forming • Medicaid ACO program in Maine
2014	• Medicaid ACO program in Vermont • Largest number of states expand Medicaid: AZ, AR, CA, CO, CT, DE, IL, IA, KY, MD, MA, MI, MN, NV, NH, NJ, NM, NY, ND, OH, OR, RI, VT, WA, WV
2015	• Additional states expanding Medicaid: AK, HI, IN, PA
2016	• Additional states expanding Medicaid: LA, MT
2019 - 2021	• Additional states expanding Medicaid: ME, WV (2019) ID, NE, UT (2020) MO, OK (2021)
	• States with no expansion: AL, FL, GA, KS, MS, NC, SC, SD, TN, TX, WI, WY

Medicaid increasingly private / administered with some focus on value



- The overwhelming majority of states have moved to a Managed Care Organization (MCO) model
- An additional 6 maintain dual models: MCO and Primary Care Case Management (PCCM)
- 6 have only a PCCM model
- 3-4 have only FFS models*

* VT has a unique model that approximates managed care but is state administered. It could be considered a PCCM-type model

Formation & Purpose of the LAN

HCPLAN
Health Care Payment Learning & Action Network

Launched by the U.S. Department of Health and Human Services (HHS) in 2015, the LAN was created to bring together partners in the private, public, and non-profit sectors to transform the nation's health care system to emphasize high quality, efficient, and affordable care via alternative payment models (APMs).

Since its inception, decision makers from these stakeholder groups have worked together through the LAN to align efforts, capture best practices, disseminate information, and apply lessons learned.

APM Models

HCPLAN
Health Care Payment Learning & Action Network

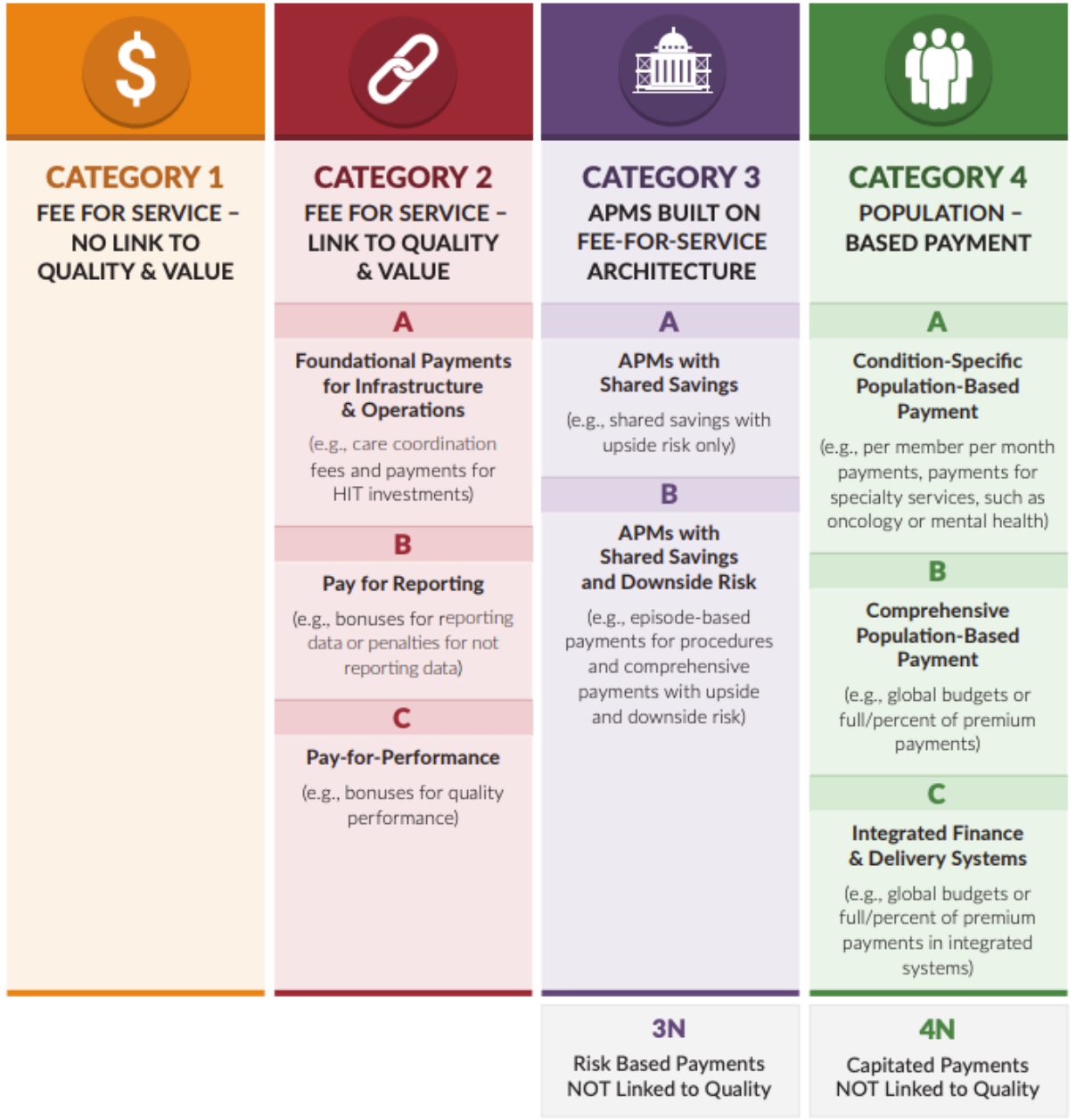
Our Goal Statement

Accelerate the percentage of US health care payments tied to quality and value in each market segment through the adoption of two-sided risk alternative payment models.

	Medicaid	Commercial	Medicare Advantage	Traditional Medicare
2020	15%	15%	30%	30%
2022	25%	25%	50%	50%
2025	50%	50%	100%	100%

All content is from the Health Care Payment Learning & Action Network.

More info about the network: http://hcp-lan.org/workproducts/HCPLAN-Overview.pdf
Info about the supporting collaborators: https://hcp-lan.org/supporting-organizations/

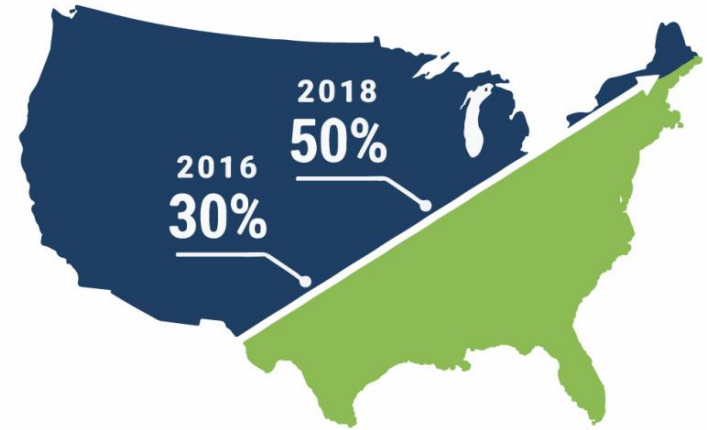


The Healthcare Payment Learning and Action Network

History of the LAN

Original Mission & Goals

To accelerate the health care system's transition to alternative payment models (APMs) by combining the innovation, power, and reach of the private and public sectors. The shift from fee-for-service to paying for quality via APMs is aimed at achieving better quality, better health, and lower cost.



GOALS

Goal of U.S. health care payments linked to quality and value through APMs in Categories 3 & 4* of the APM Framework.

RESULTS

2015 Data: 23%
2016 Data: 29%
2017 Data: 34%
2018 Data: 36%

***Category 3:** APMs Built on Fee-for-Service Architecture
Category 4: Population-Based Payments

HCPLAN
Health Care Payment Learning & Action Network

What have we learned?

Three guiding principles for Network Formation

I want to start with three principles that have guided my career and interest in this work since 2007:

1. Doing this work has been and always will be about maximizing the resources to serve underserved communities.
2. The organizations who fully capitalize on the shifts in healthcare reimbursement will gain and maintain considerable influence over how money is spent and thus how and where care is delivered.
3. Getting the technical details of Network Formation right is paramount to success, but nothing else matters if we do not fundamentally change behavior at the point of patient/care-team interaction.

#1 Maximizing resources to serve your community

- Forming new partnerships is critical to improving the health of the communities you serve:
  - Managed Care Organizations are not the enemy, but they are an increasingly important partner in the markets they serve and operate in.
  - We cannot expect them to share our precise mission, but we CAN expect them to listen to changes that will result in healthier populations and lower costs.
- Example: Every Health Center network MUST have a strategy for "persistent validation of ICD-10."
  - Under-coding disease is common, especially in Health Centers.
  - Insurance status churn only makes it more complicated.
  - Properly coding every patient, every year determined MCO compensation.
  - MCO compensation determined Health Center/Network compensation in properly negotiated contracts.

#2 Seizing the opportunity

- When we look at how the health system has been organized over the last two decades, it has been the result of the LAST ROUND of significant health reimbursement system disruption:
  - We are the experts in community-based care but for 20 years healthcare has been dominated by large health systems.
  - That is not by accident: these systems seized onto opportunities in past disruptions.
  - If we don't seize the opportunities presented now, we should expect to be subsumed by others' vision for health delivery.
- Example: States deferring to academic medical centers over community providers
  - Antiquated systems of risk adjustment may make health system care APPEAR to be more cost effective.
  - These systems of risk adjustment do not have data inputs associated with social determinants of health, nor do they take into consideration community organization and resource availability.

#3 Nothing else matters

- There are keys to success, many of which we have helped networks accomplish, that should be priorities in the network formation phase. These ALL MATTER:
  - Evaluating a business case and making decisions about areas of focus.
  - Determining the right governance, equity, and distribution models.
  - Setting up the right committees and setting standards.
  - Determining infrastructure needs and finding partners.
- But nothing matters AT ALL without modifications to practice.
- Example: The quickest way to failure is the "Health Centers are already the most cost-effective setting of care" mentality.
  - Even if national or state-level results may demonstrate this, there is so much variation that there is always room for improvement.
  - Medical care alone only impacts 10% of mortality and morbidity, and while we may be the pioneers in addressing social and environmental impacts on wellness, value-based payment should fundamentally shift our ability to invest in these areas.

So what have we learned?

We will explore each of these in discussion form, led with examples from real-life experience of your peers including many of the people on this call!

#1 Structure still matters

The use of a third-party entity is still the ”standard” for entering the Clinically Integrated Network space:

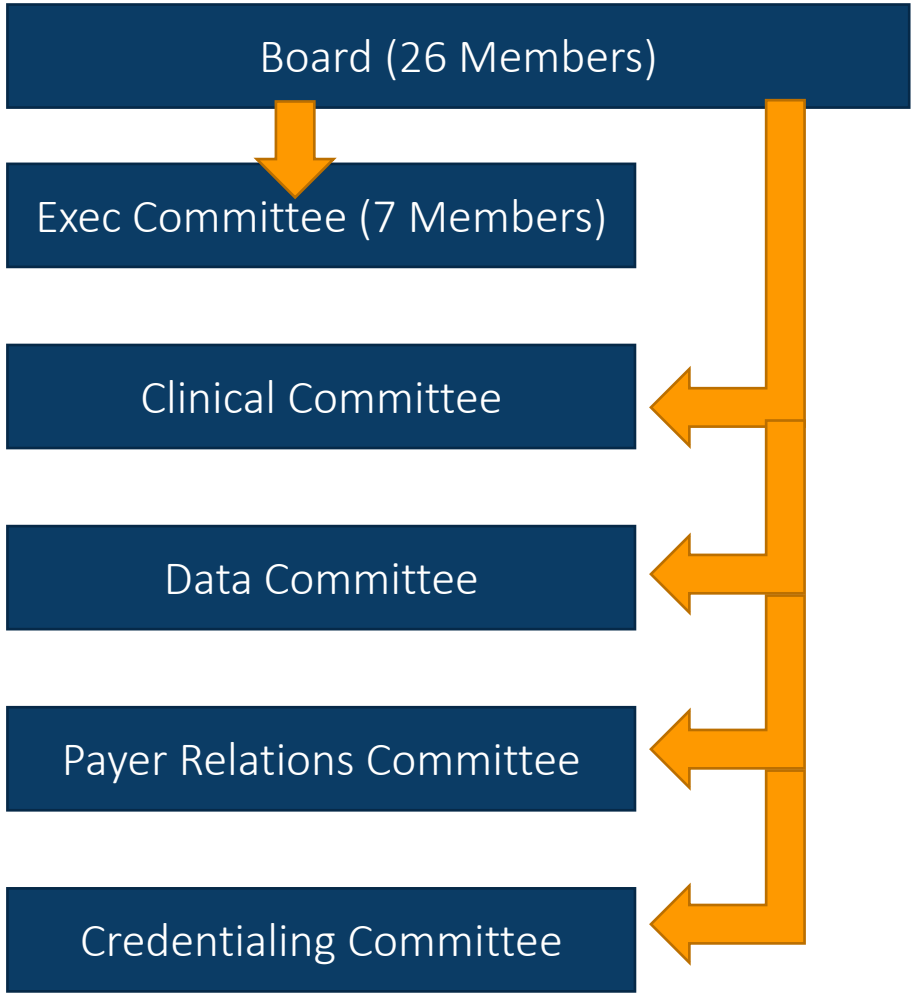
- It still offers a level of protection from anti-trust issues for the PCA and/or any individual Health Centers (but isn’t perfect.)
- If does offer financial liability limitations in most cases.
- It allows for distinct governance and equity rights to its owners/investors/participants.
- It creates a tax-efficient pass-through vehicle
- It allows its participants to meet specific requirements of value-based programs without modifying existing organizations.
- Set up right, it can serve as an ACO, CIN, IPA, delegated credentialing entity, managed services organization and (in rare case) even grow into an MCO-like entity.

#1 Structure still matters

Things that matter a LOT	Remedies
• Participants need considerable control of the entity.	• Participants "owning" an interest can create unintended consequences and has little real upside. Instead, use distributions and have specific rules for an exit.
• Entity should not be held or controlled by for-profit entities (or intermediate entities controlled by for-profit entities.)	• Bring third-parties and for-profit partners in as vendors. • Any and all contracts held (payer contracts, vendor contracts, other contracts) should be under the auspices of the entity's governing bodies.
• The size of the Board should be small	• All entity governance bodies should be clearly defined and have appropriate authority to do their work. Specifically, there should be smaller bodies within governance that can act to capitalize on fast-moving contracting processes.

#1 Efficient Governance for Getting the Work Done

- Keeping a Network lean on cost requires that participants play key roles in running the network.
- A representative Executive Committee with clearly defined decision-making authority is critical to being efficient.
- A Board can offer opportunities for input to the broader Participant group.
- Functional committees do a lot of the "work" of running a Network.
- All of this requires that rights and responsibilities be clearly defined and processes to enforce them are created.



#2 Long-term outlook is critical to success

Clinical Integration takes time and money, and while it makes sense to have a plan to get to ROI quickly, it is the long-term ability to influence healthcare spend that ultimately matters:

- Especially at first, payer contracts may not be much better than what SOME participants may be able to get on their own.
- Ultimately, though, they should be better than the sum-total of the collective group can get on their own.
- Many early contracts are “templates” that MCOs are using nationally.
- As we integrate further, and more deeply, we gain safe-harbors that will allow us to utilize our collective leverage further. More importantly, if we’re good at what we say we are going to do, they won’t be able to deny us better contracts in the future.
- A long-term perspective also means pushing the risk/reward balance of payer contracts. *This can include HCP-LAN Category 4 payment models.*

#2 Long-term outlook is critical to success

Things that matter a LOT	Remedies
• Leaders who are focused on the collective good, even if some sacrifices are made year 1.	• Consider how your distribution methodologies reward high-performers while ensuring investment in those who need to catch up.
• Maintaining patience as to the level of return in year 1.	• Early year gains should be evaluated for strategic investments in future capacity and reserves (more on this next)

#3 Determining sustainability

It is unrealistic to expect a network to do all of the necessary work to facilitate considerable gains without an appropriately sized budget that includes:

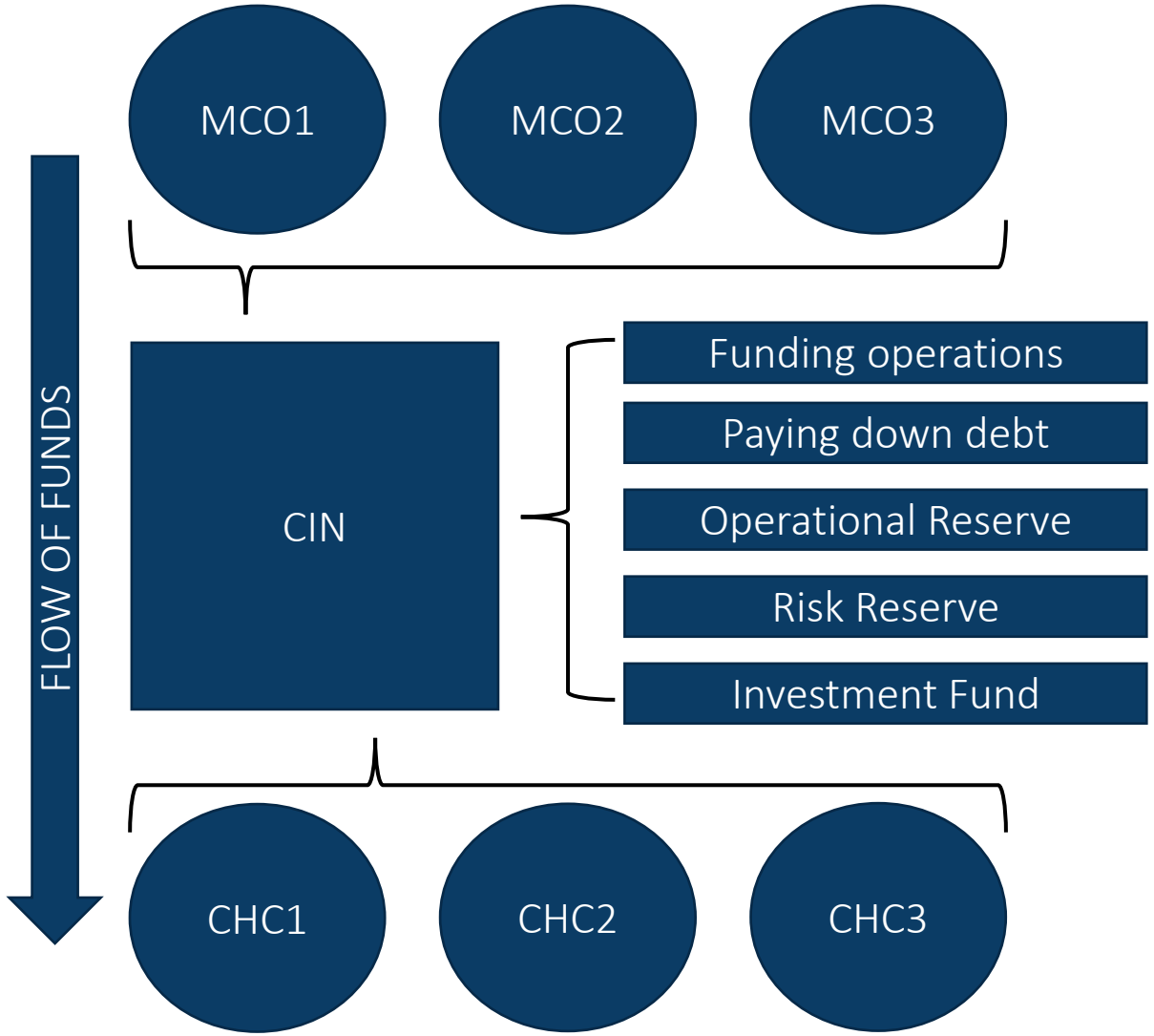
- A reasonable operating budget (staff, vendors, etc.)
- An operating reserve (90-days on hand?)
- An investment reserve – for planned expenditures (saving up for a new IT system.)
- A risk reserve – For unintended losses within contracts (money needed to take on downside.)
- A strategic reserve – to capitalize on new opportunities (we want to respond to a state RFP to be an MCO and need seed funding)

You can skip funding some of these in some periods, but the "long term" outlook suggests that reserve funds are critical to enhancing influence.

#3 Determining sustainability

Things that matter a LOT	Remedies
• You cannot distribute every dollar. If you do, you will have to call additional capital constantly.	• Determine upfront administrative costs on contracts. In early years over-estimate. You can always distribute more later.
• Strategic planning focus for later years.	• Determining an operating model, staffing model, and necessary vendor contracts early. • Solid day-to-day financial planning and control for operations and future investments. • Actuarial (or similar) capabilities to determine strategic reserve needs / risk. • This is a key area where exploring third-party support makes sense.

#3 Creating Sustainable Investments



- While the goal is to flow as much of the value-based funds to Health Centers (eventually) give considerable thought to whether you need to fund other initiatives.
  - Funding operations
  - Paying off debts
  - Reserves
  - Future investments
- Early in Network maturity the Network may feel like a lot of overhead, but it is the vehicle to do the work and legally capture the financial reward. That doesn't come without investment.

#4 Establishing a vision for distributing gains

It is important to have an early vision for how to share gains with participants. Models for distributions should follow a series of best practices designed to motivate behavior change at the individual participant organizations. Best practices:

1. Have a clear distribution philosophy that is applied to all contracts.
2. Publish and ratify a contract-specific distribution methodologies between 4 and 6 months prior to the beginning of the performance period.
3. Mirror measures of performance within the contract but prioritize measures that demonstrate that participants are modifying behavior.

#4 Establishing a vision for distributing gains

Things that matter a LOT	Remedies
• Changing behavior.	• Choose and prioritize measures that prove that an organization is actively participating. • It is surprising how much measures around attending performance reviews, conducting basic wellness visits, and accessing and utilizing core information systems for performance data matter.
• Expecting / incentivizing investment.	• Publishing a methodology early allows the participant organization to properly staff and train. • For low performers, consider performance improvement plans.

#4 Establishing a vision for distributing gains

- The Network's contract with the plans will determine the criteria for earning incentives.
- The Network establishes a set of performance criteria that will vary the payments out of the Health Centers.
- Most high-functioning networks vary the criteria for distribution to Health Centers to be based on demonstrated effort applied to the work:
  - Participation in meetings / performance reviews
  - Preforming key engagement processes such as Annual Wellness Visits
  - Achieving clinical outcome goals
  - Improving on utilization measures, such as ED and rehospitalization

#5 Standards-based versus centralized capacity-based integration

Integration loosely means that the network has capability to motivate participants to do some things the same. One way this can be done by setting standards and requiring the meeting of these standards as part of a distribution methodology. The other is to simply provide the capacity within the network. For example:

- Standards based: every Health Center will maintain 1.0 FTE care coordinator for every 500 high-risk patients in a specific contract and will only receive the PMPM if they can prove this.
- Central capacity: the network hires 1.0 FTE care coordinator for every 500 high-risk patients. A portion of the PMPM is retained at the network.

#5 Standards-based versus centralized capacity-based integration

Things that matter a LOT	Remedies
• Assess preferences for which model to employ.	• Is it consistent with the participants' expectations that they will be required to make investments locally? • Are participants comfortable with a centralized team that interacts directly with patients?
• Being flexible.	• Especially in larger or more diverse networks, consider hybrid models. • Smaller health centers get centralized support for a higher cost. • Larger health centers hire to meet the need and receive a higher distribution.
• Being clear.	• Publish early, collaborate with participants on progress, and determine ways to measure success.

#6 Unlocking the Managed Care Data Set

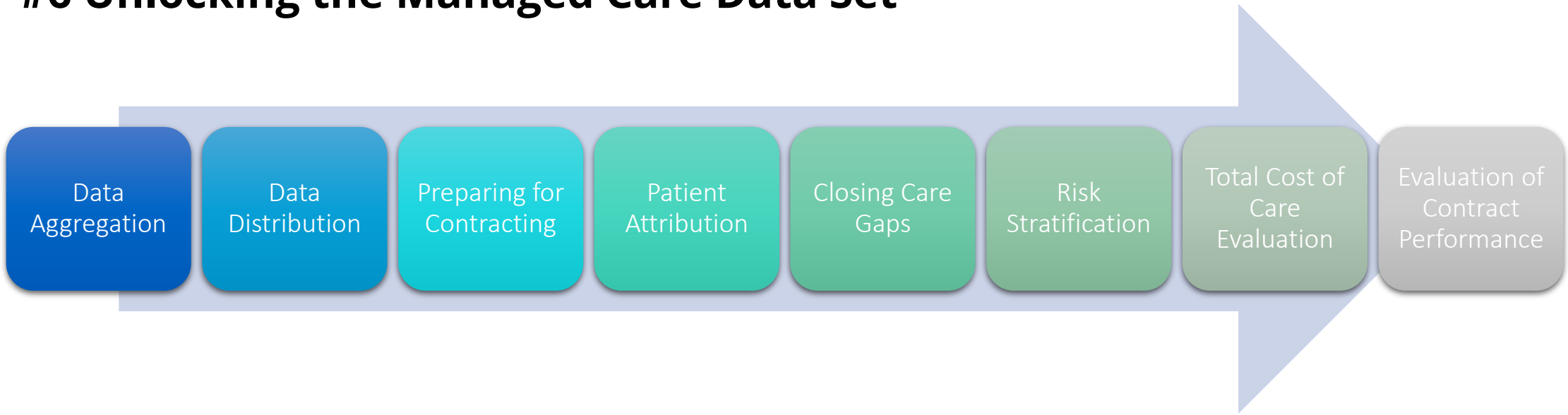
The Managed Care Data Set is not new to Health Centers, but for the first time we are seeing bulk sharing of data to support new payment methodologies:

- The Managed Care Data Set includes:
  - Attribution / empanelment data
  - Risk data
  - Utilization data
  - Cost / paid claims data
- This data can be a game changer for networks:
  - Allows network to understand which gaps are quality issues and which are data issues.
  - Understanding total cost of care and how to influence it requires a source of data.

#6 Unlocking the Managed Care Data Set

Things that matter a LOT	Remedies
• Ensuring that the data you receive is consistent with the level of risk in your contracts.	• In basic P4P (HCP-LAN Category 2B) might only require attribution and care gap data. • Shared savings / loss require AT A MINIMUM cost benchmarking data. • Anything beyond shared savings requires detailed paid claims.
• Getting access to the data on a consistent basis and having a plan to quickly load and analyze it.	• MSSP gives trailing data once a month. The time to put it to use is as soon as it is released.

#6 Unlocking the Managed Care Data Set



A whole new set of use cases exist once you can access managed care data. Organizations that do this well are more likely to be successful in value-based contracts.

This work scales considerably: doing the work for 30+ health centers is minimally more technically complex than doing it for 1. Yet, it is not inexpensive work.

#7 Dedicated Staffing

Full-time work cannot be accomplished with bits and pieces of part-time focus. It is usually a key pivot point for early networks when they bring in dedicated staff, and the results can be considerable:

- Some roles can be handled with limited allocations from PCA-based staff:
  - Finance, HR, basic IT
- Certain functions need dedicated staff:
  - Contracting/payer relations, performance assessment, participant relations

#7 Dedicated Staffing

Things that matter a LOT	Remedies
• Heading off contentious conversations about the relationship between the network and the PCA is critical.	It is still best practices to: • Place a master services agreement between the network and PCA so the PCA can provide services. • Determine and utilize an allocation and compensation formula to keep the PCA whole on network activity. • Consider reasonable compensation for part-time contributions such as HR on a low-percentage basis (0.1FTE) • Allow for the hiring of dedicated staff at the PCA to work 100% for the network, with clear expectations on how this is paid for and who this person reports to.

#8 Diversified portfolio of contracts and programs

The network should explore all options for sustainability:

- It can be tempting to try to make all contracts look the same, but there are missed opportunities in doing this.
  - Use some contracts to push the envelope into new payment models.
  - A portfolio that includes consistent, guaranteed revenue opportunities, some reasonably attainable upside, and some reach goals with large windfall potential works well.
- There are considerable additional opportunities for a network to improve financial and operational performance of its participants:
  - Delegated credentialing is the most commonly cited / implemented shared services.
  - Others are exploring additional shared QI and IT capabilities, joint purchasing of things like health insurance, and other ways to leverage the network.

#8 Diversified portfolio of contracts and programs

Things that matter a LOT	Remedies
• Maintain a forecasting tool to help understand revenue.	Consider some of the following: • Medicaid payment models with per-member, per-month guaranteed payments to support month-over-month sustainability. • Some basic pay for reporting, such as reporting a completed SDOH survey, that create low-hanging fruit for generating revenue. • Some opportunities to hit "home runs" to provide a cushion of reserve. The MSSP, for example, can generate large windfalls on small population sizes.
• Explore opportunities for non-payer revenue	• Delegated credentialing is an excellent option, but there are others.

#8 Meaningful Service Lines to Support Integration and Outcomes

Service Line	Purpose
Payer Relations	• Negotiate contracts and manage payer commitments • Participate in periodic performance reviews
Delegated Credentialing	• Efficient credentialing processes for providers and Health Centers • Oversight for credentialing approval, speeding up time to payment
Data Analysis	• Data aggregation of EHR and payer data sources (and others) • Standardized reporting for each Health Center • Normalize data across sources (e.g. health plans) to support efficiency
Revenue Cycle Management	• Tools and potential outsourced resources to maximize reimbursement under current contracts
Performance Management	• Periodic review with each Health Center to help them ensure a good financial outcome for the work they are doing


Where do we go from here?

These are my priorities for how this work evolves:

1. How can we leverage successes across states? Specifically, how can we find ways of creating the same capacity that for-profit partners wish to "sell us?" It would appear there is way more scale to be generated.
2. Who will take the first step towards significant exposure to HCP-LAN Category 4 models? What level of enhanced risk makes sense? Determining effective approaches and keeping pace with evolving markets will be essential.
3. What will solutions look like in markets that have not expanded Medicaid or Managed Care? How can they make a strong business case to do something different?
4. Can we discreetly measure and prove the impact of addressing social determinants of health, thus creating sustainable revenue streams for applying resources to upstream challenges?