Population Health 360
A COMPREHENSIVE LOOK

Round Table Discussion Notes

Value-Based Payment Contracting with MCOs

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Bristlecone 6

Round Table Facilitators

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Difference in value-based contracts from each coast	• NY – On Medicaid – as states change certain laws, we have to work to find the right partners to cut costs to continue to be successful • NY – It is possible to make money in the Medicaid space, with the right partners, health homes in particular • CA – DHS wants to carve-out pharmacy out of the health plans in the state • NY – with spread pricing coming down, providers are trying to renegotiate spreads; trying to work with the pharmacists directly- PBM rebating and repackaging
Motivation and goals behind making the transition (Payers vs. Providers)	• Working with providers to get out of bad arrangements with payors who have opportunities to save money, serve people better in a value-based way. She has to fight for clients in this space continuously.
Sharing data and building trust between partners	• NY – carve out of pharmacy happened years ago, and it did not go well, because the data did not come back to the providers or health plans, so everyone involved had disparate information and not the full picture – large data problem • Pharmacy data is a gold mine – if you break the link between payors and pharmacy, you gain critical data from a clinical and cost perspective • Providers need adherence data – use telehealth for value-based arrangements, as well as some medi-cubes to be able to see adherence for medications for up to 18 medications for patients • In VBP arrangements – need to look at the pharmacy data in big lump sums at the detail level – who wrote it, how much, where is it getting filled • Stop loss focus discussion • Moving providers away from payor stop loss, looking at medical versus drug coverage

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	• Being a part of the PT/UM conversation and working with the pharmacists, and doctors is key in a VBP system
How do you design the right network? Access standards, right doctors	• Consumption of care behavior based on the difference in population (age, behavior) • Looked at a fully web-based care model, one episode – done, no continuity → decided this network was not compatible with their model (and too expensive) • Has 5 generations that work for him, what they do – mobile portals for some practices really good, using a lot of wearables to draw data into the system so it's part of the medical record and query it and run reports • We are providing wearables to their patients, it's cheaper in the long run – brand loyalty and good scores • Sacramento example – worked with 4 community partners who all brought $5M to the table each in an FQHC model • Likes to employ the patients – great word of mouth for advertising → FQHC leads the care model, want patients to have a primary care home, want to break the cycle that the hospital is the health home • Struggling to work hard to build a model that is structured around FQHCs
What is the appropriate role of a broad FQHC in a value-based network	• Volume is not the model – world he sees in the future is going to be cost • Has a specialty in the FQHC a day or two a week • Doesn't have non-FQHC in the market • Price difference of the providers seeing certain patients in a regular office visit versus in an FQHCs • 90% MLR, with $5 PMPM – don't have downside, but they do have shared-risk • Looking at what is included in reconciliation – looking for a model that is able to incentivize for quality and HEIDS scores – but don't penalize because you will lose provider engagement
IBNR question	• IBNR-Very careful about a lag and really proactive about managing, in TTC its called a "claims lag" and the health plan partner reserves for that, but they have an 18 month run out and they don't want to settle the previous period as they are very conservative and then you are already in a new contract, but because of the claims las • Always 18 months behind – some offer quarterly reports with IBNR built in, other plans hold data for 18 months until fully run out • We are very traditional for IBNR for actuarial, if its TTC its different (missed what he said) – its relationship based
Total cost of care and bundles question– how do you build the right bundles for those specialties?	• Has not crossed over bundles into the risk areas because they are at risk already so they have been traditional/ conservative in the approach • Using Prometheus in software – it's all about how you engage the specialist or they don't want to play

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Medicaid individual marketplace conversation – how is it treated like a business line?	• Defines individual as a subset of Medicaid – see it as one book that is Medicaid focus (in CA), in Oregon its seen more as commercial • How are they seeing it and how are they targeting sales? → Stand-alone commercial because of the way Texas sees Medicaid • Are you seeing it behave more like a Medicaid population due to social determinants or seeing it more like commercial – it's a healthy, price sensitive population with fair share of high risk • NY – individual market is treated like Medicaid even though they don't behave that way, started to be carved out of AVO and VBP arrangements and treat them like Medicaid (they were healthy good people who should be targeted for preventive care) • Non expansion states are really the ones to watch – and claims data of these people through their lifespan

Working Definitions:

- Value-based:
  - Anything for dollars based on quality performance → good place to start, not a good place to land
  - Truly want to get to total cost of care (intimate relationships with payors at the premium level down to MLR), or capitation
  - Adventist is pushing very hard to do risk arrangements in Medicare, Medicaid, commercial is the 3rd issue, not the first