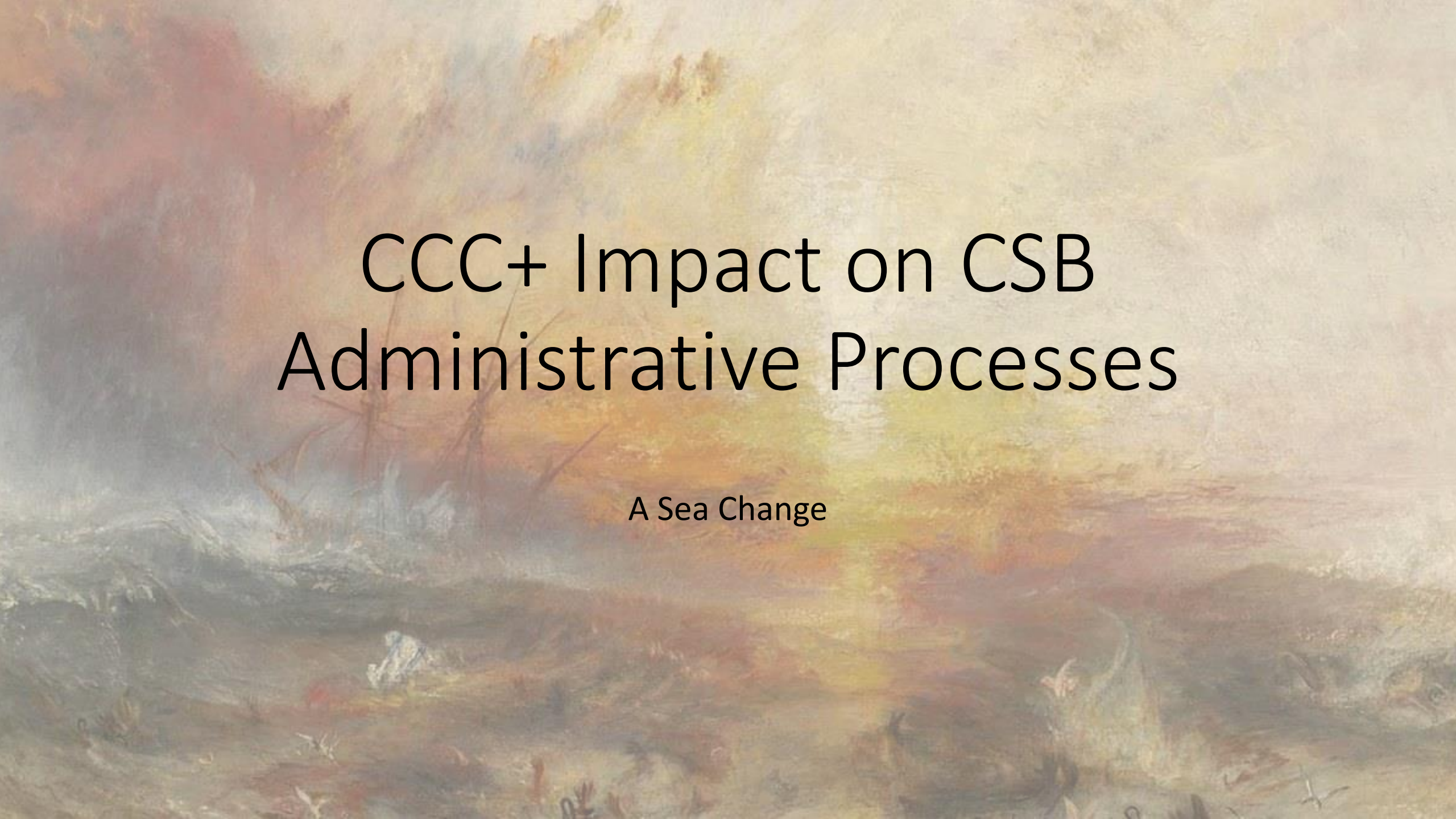


CCC+ Impact on CSB Administrative Processes

A Sea Change

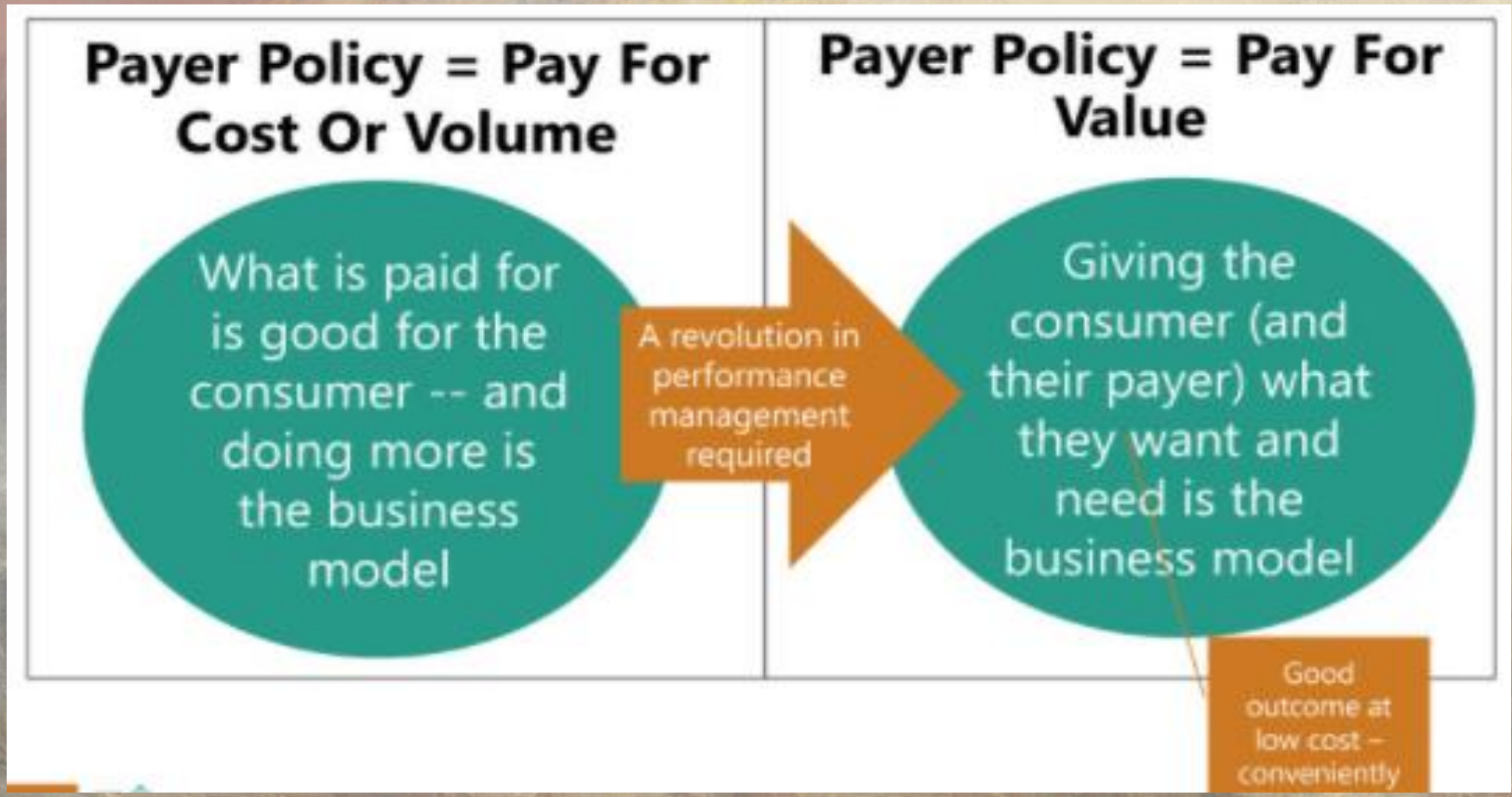
Things To Consider

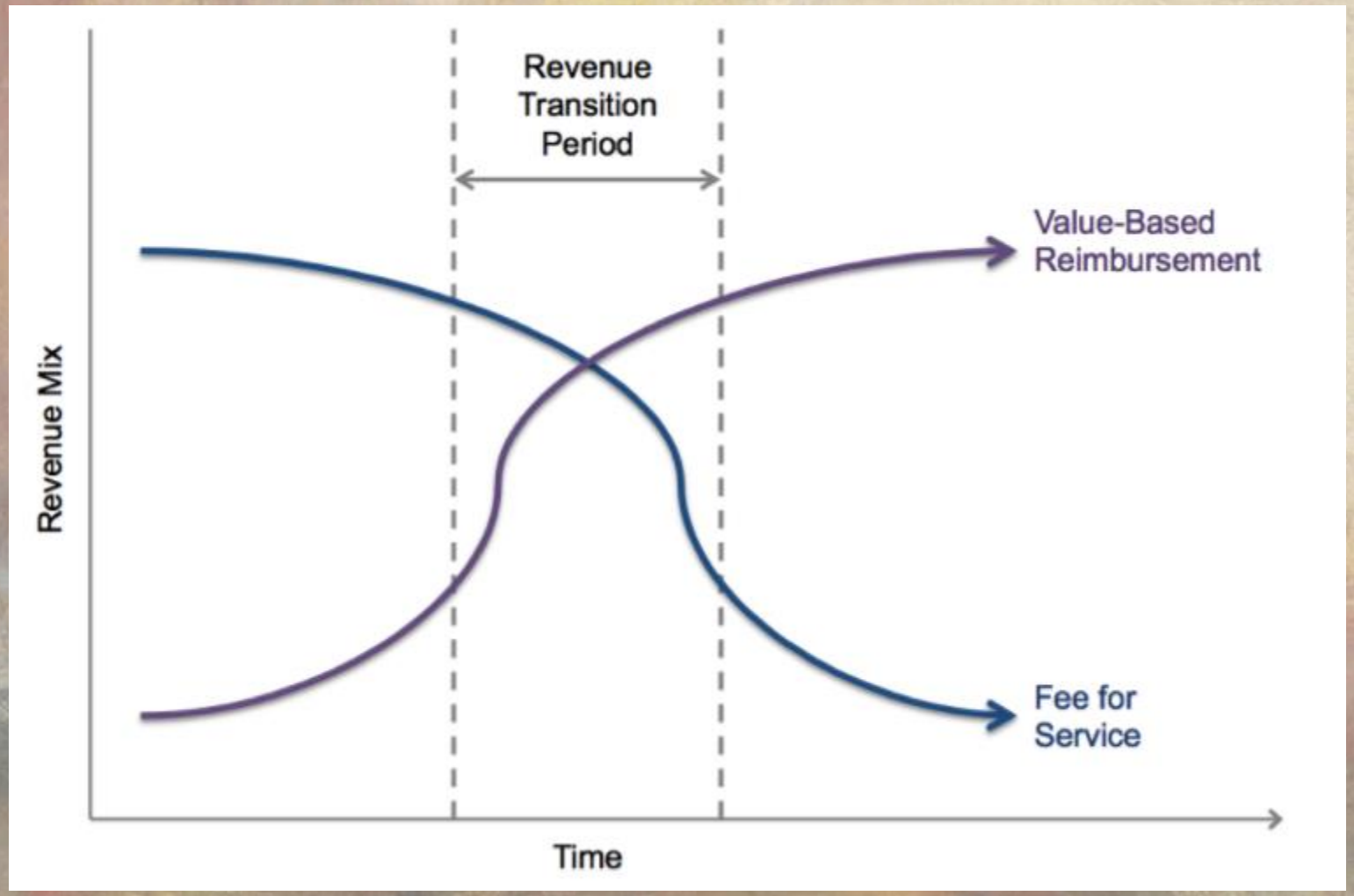
- Higher Administrative Costs
  - No increase in Medicaid rates
  - Verification of member eligibility and verification with payers
  - MCO Provider Portal Management – Multiple Payers, Multiple Provider Portals
  - Differing MCO Provider Manual Requirements
  - Tracking Registrations/Authorizations timeframes
  - Denial Management
  - Desk Audits with Multiple Payers
  - Need to track provider credentials (for both LMHPs and QNLPs) over time
  - Different Electronic Funds Transfer (EFT) / Electronic Remittance Advice (ERA) set-ups
  - Centers for Medicare and Medicaid Services (CMS) requirement to verify information in payers provider directories every 90 days
  - Increased requirements for supervision of QMHPs and QMHP registration costs
  - No increase in Medicaid rates

Things To Consider (Continued)

- Transitioning from Fee-for-Service to Value Based Payments
  - Partnering with multiple MCOs with differing priorities
  - Measure What Matters – Who, What, When, Where, How
  - Change to a data-driven culture focused on outcomes

The Transition




Revenue
Transition
Period
Value-Based
Reimbursement
Fee for
Service
Revenue Mix
Time

But How To Make This Happen?
The Road To Value-Based Health & Human Services

Set Performance Standards
Decide What To Measure & Measure It

Metrics-Based Management
Develop Systems & Process To Use Performance Measurement In Management

Performance-Driven Culture
Use Performance Measurement Data To Change The Organization

Where are we headed?

- Beginning in the CY 2019 contract year, DMAS plans to set targets in the Contract for all Value Based Payments(VBP) (categories 2-4) and Alternative Payment Models (APM) (categories 3-4). We should expect the targets to increase by at least five (5) percentage points each year from that point moving forward.
- VBP and APMs:
  - Payment models classified in Category 2 utilize traditional FFS payments (i.e., payments made for units of service), but these payments are subsequently adjusted based on infrastructure investments to improve care or clinical services, whether providers report quality data, or how well providers perform on cost and quality metrics.
  - In addition to their capacity to stimulate and focus quality improvement initiatives, investments in quality performance assessment are also valuable because they can drive the development and expansion of health information technology (HIT).

VBP and APMs

- Category 3 APMs must hold providers financially accountable for performance on available measures of “appropriate care.”
  - In this context, appropriate care is delivered when patients receive the right care at the right time, in the right place, and at the right intensity.
  - Appropriate care adheres to evidence-based guidelines and comparative effectiveness research; it avoids unnecessarily costly, harmful, and unnecessary procedures; its intensity is commensurate with patients’ goals, prognoses, and needs; and it reflects the outcome of shared decision-making among patients, their caregivers, and their clinicians.
- Payment models classified as Category 4 involve prospective, population-based payments, structured in a manner that encourages providers to deliver well-coordinated, high-quality, person-centered care within either a defined scope of practice (4A), a comprehensive collection of care (4B), or a highly integrated finance and delivery system (4C).
  - For the same reasons as Category 3, Category 4 APMs require accountability for measures of appropriate care to provide additional safeguards against incentives to limit necessary care. Absent this accountability, APMs that use prospective, population based payments will be classified in Category 4N.

Want to know more?

- Value Based Payments (VBP) is a broad set of payment strategies intended to improve quality, outcomes, and efficiency by linking financial incentives to performance. Measurement is based on a set of defined outcome metrics of quality, cost, and patient-centered care. Each of the plans must establish a VBP strategy that follows the Alternate Payment Model (APM) framework in the Final White Paper developed by the Health Care Payment Learning and Action Network (HCP-LAN) with a special emphasis on categories 3 and 4. The White Paper can be accessed at https://hcp-lan.org/2016/01/final-apm-framework-white-paper/.
- For additional information, refer to the CCC Plus Final Contract with the MCOs, available here. See Section 13, page 177 on Value Based Payments