Alternative Managed Care Reimbursement Models

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Healthcare Reform Trends in 2015

- Moving from carve out Medicaid BH funding to Section 1115 Integrated Waivers (Alabama, Arkansas, Kansas, Illinois, etc.)
- Movement to Care Coordination Entities and Managed Care Community Networks (Illinois, Oregon)
- Accountable Care Organizations (ACOs) are being certified by CMS with over 165 announced Certifications for both Medicare and now Medicaid Share Savings Plans
- 14 plus states have applied under Section 2703 of the ACA to develop Integrated Care Health Homes
- Payer focus on high-needs complex consumers – with preference for coordinated care across medical, behavioral, and
- Moving from paying for volume of services to paying for value/ quality of services
Key Strategy and Outcomes for Alternative Payment Models

To align incentives between health care payers and providers to better coordinate care, enhance prevention and disease management, reduce avoidable utilization and total costs, and improve health outcomes.

“Value” of Care Equation

1. **Services provided** – Service array, duration and intensity of services through Level of Care/Benefit Design Criteria and/or EBPs
2. **Cost of services** provided based on current service delivery processes by CPT/E&M or other code and staff type
3. **Outcomes achieved** (i.e., how do we demonstrate that people are getting “better”)
4. **Value is determined** based on can you achieve the same or better outcomes with a change of services delivered or change in service process costs which makes the outcomes under the new clinical model a better value for the payer.
Institute for Healthcare Improvement - The Triple Aim

With hospitals moving toward a value-based payment system there is more demand now than ever for strategies that will help healthcare systems hone in on population health. The Triple Aim, an initiative set forth by the Institute for Healthcare Improvement, covers three main checkpoints for all hospitals as they make this transition:

- Population Health Focus
- Experience of Care
- Lower Per Capita Cost


Institute for Healthcare Improvement – Triple Aim

The success of achieving the Triple Aim relies on a few steps:

- Identifying target (or at-risk) populations
- Find out and define what your system's aims and measures will be
- Develop a project that will show your progress and evidence to support system-wide change
- Scale up testing for populations – look at the community you serve first, those are your potential patients: by understanding their socioeconomic and health state at a population level, you'll better predict their needs.

Source: A Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost

The Rating of Performance in Healthcare

- CMS Quality Initiatives
- National Committee for Quality Assurance (NCQA)
- National Quality Forum (NQF)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- The Joint Commission
- Payer and care management organizations (states, counties, HMOs, MCOs, PPOs, ACOs, etc.)

Is Pay for Performance in the Future?

- Rationale –
- To Achieve **Quality Metrics**
- **Collaboration to Achieve the Triple-Aim:** improved quality, affordability, and patient satisfaction
- **Increased market demand** for lower cost/higher quality services
- **Demand from consumers** for high-quality care and transparency into cost and quality
Pay For Performance

• Why should a payer pay me more?
• In trying to answer this question, stay away from any answer that pertains to the effort that you put forth.
• For example, every provider that provides XYZ services in one community all reports that they are treating the most severely ill people…. that can’t be true!
• Is your healthcare organization built for high volume and serious illness?

Maximizing Value for Consumers and Payers

Achieving the best outcomes at the lowest cost.

Move from a supply-driven health care system organized around what clinicians do and toward a consumer-centered system organized around what consumers need.
Providers and MCOs Jointly Leading the way to make Value the Overarching Goal

• Requires Transformational change
• Revenue is misaligned with the interest of consumers, because revenue and profit depends on increasing the volume of services, not delivering good results.
• Improving outcomes that matter to consumers relative to the cost of achieving these outcomes will result in progress.

Pay for Performance

• Payment or financial incentives for achieving defined and measurable goals related to care processes, and outcomes
• Offers potential to improve quality of care, encourage collaboration, and enhance efficiency of care
• Limitations include single condition focused measures that do not reflect the complexity of caring for patients with complex cases
• May incentivize physicians to avoid high risk patients
Quantifying Value

• Can you promise anything that will lead to savings for the payer?
• Can you promise anything that will lead to improved outcomes?
• What is the effect of the services that you provide?
• And how do you know that you get that effect?
• Can you state your value in a few simple sentences?

Converting from Payment for Volume to Payment for Value

• Aligning how we pay for services with the outcomes we are attempting to achieve – better health, better care and better costs.
• Services must be effective in achieving individual outcomes or system-wide outcomes;
• The services are more cost-effective than alternatives that may have been selected;
• The services are “lean”, waste (excess costs) have been removed through process improvement activities.
“Value-Based Purchasing” Model

1. Payment Reform is moving from “paying for volume to paying for value/quality”
2. VBP requires integration of our clinical, quality and financial information and the ability to track and analyze costs by consumer, provider, team, program, and payor and can operate effectively under fee for service, case rate, and sub-capitation payment models in order to succeed under a variety of Pay for Performance (P4) bonus arrangements.

Value-Based “Shared Risk” Payment Model Core Elements

1. Know cost per service/staff type
2. Identify clinically recommended service mix, frequency and duration per level of care/intensity of need (i.e., ASAM, DLA-20, ICD-10 CM) to support determination of costs of bundled/episodic care needs
3. Provide outcomes to demonstrate reduction of high/disruptive cost services (i.e., reduction in ER visits)
Shared Risk Funding Model Requirements

1. **Important definition of Value/Quality:** The outcomes achieved to objectively demonstrate that the client is getting better combined with the service array frequency and duration provided, and the cost of the process of treatment linked to the outcomes achieved.

2. Ability of all staff to develop a *dynamic tension between “quality” and “cost”* as if they are on a pendulum

3. Ability to know levels of NET revenue received for services provided – NOT RATE for service billed
   a. What is the claim denial/error rate last week, month, quarter, etc.?
   b. What is the level of over utilization of capped/grant funding received that reduces the net revenue earned per service (i.e., $82 per hour therapy rate reduced to $39.75 per hour net revenues earned due to over utilization of capped/grant funding contracts)

Provider Reimbursement Models

The BIG Question - Accountability In Healthcare?
Shared Savings Potential for Health Plans and Customers

Substantial

Partial Risk

Full Risk

Episodic Cost Accountability

Total Cost Accountability

Traditional Fee-for-Service

Pay-for-Performance

Bundled Payments

Shared Savings

Minimal Savings Potential for Health Plans and Customers

Source: The Advisory Board Company: Accountable Care Forum-Briefing for Health Plan Executives

Business Intelligence Necessary to Enter Into Value Based Purchasing

- Do you know the costs of the services provided?
- Do you know the time needed to move someone from first call to initial treatment?
- Do you produce outcomes that you can show in data for the following:
  - Engagement in treatment
  - Readmission rates
  - Hospitalization rates
  - Symptom reduction through objective tool measurement
Information Needed to Develop an Alternative Reimbursement Method

➢ What is the purpose of developing an alternative payment method.
  o What values are we trying to achieve?
  o What outcomes are we trying to achieve?
  o What service gaps are we trying to fill?
  o How will we know if this strategy works or not?
➢ Which method are we considering using?
  o Why do we think that changing the payment method will achieve the desired results?
➢ What service or services are included in the new rate?

Information Needed to Develop an Alternative Reimbursement Method

➢ Implementation Strategies
  o What strategy are you going to use to implement a new payment method?
  o How will a new method affect providers?
    • Reporting issues
  o How will a new method affect consumers and access to care?
  o How will a new payment methodology be explained to stakeholders?
    • What are the upside and downside considerations?
    • How are you going to manage downside risk to all stakeholders?
Basic Data Needed

- What is the population that is going to be covered?
  - What is the population demographic?
    - Age
    - Medicaid Category of Aid
    - Diagnosis
    - Geographic configuration
  - What are the historical services by the provider network?
    - What are the types of services provided?
    - How many units of services were delivered?
  - What is the amount of service historically received, looking at individuals?
    - How much service was provided to each enrollee?
    - What are the service utilization trends?

The Evolution of Healthcare Payment Models

- Among leading strategies to reform health care is the development and implementation of new payment models

- The goal of these models is to change the way physicians, hospitals, and other providers are paid in order to emphasize quality care at lower costs
The Evolution of Healthcare Payment Models

- Fee For Service
- Episode of Care Payment
- Bundled Payments
- Pay for Coordination
- Pay for Performance
- Traditional Capitation
- Comprehensive Care/Total Cost

Fee For Service

- Fee for service is the most common way of paying for healthcare services today
- A predetermined amount is paid for each discrete service provided
- The provider is at risk for the number and cost of processes within each service, but there is no limit on the number of services
- Providers receive payment regardless of outcomes
The fee-for-service reimbursement model makes it very difficult to achieve outcomes such as reductions in readmissions, inappropriate use of emergency room care, reduced hospitalizations, reduced residential or other high cost services.

The Answer: Providers must partner in health systems such as Coordinated Care Organizations, Managed Care Organizations, Patient-Centered Medical Homes, and Accountable Care Organizations where health outcome measures are highly sought and where payment options beyond fee-for-service are common.

Fee-For-Service Does Not Incentivize Desired Outcomes

The Fee-For-Service reimbursement model makes it very difficult to achieve outcomes such as:

- Reductions in readmissions
- Inappropriate use of emergency room care
- Reduced hospitalizations
- Reduced residential
- Other high cost services

WHY? – Let’s Discuss
**Fee-For-Service**

**Advantages/Incentives**
- **MBHO**
  - The primary reimbursement methodology preferred by CMS
  - Provider claims serve as encounter data
  - Claims payment process validates validity of claims by a predefined adjudication methodology
  - Supports accountability for enrollee care
- **Provider**
  - Incentive for provider to provide as much billable service as possible
  - Incentive to maintain high productivity rates
  - Allows for a wide rate of providers to participate in the system (Large comprehensive and small specialty providers may provide services under the plan)
  - Allows for more diverse place of service
  - Allows for greater geographical coverage (rural vs. urban)

**Disadvantages**
- **MBHO**
  - Offers little or no incentive to deliver efficient care or prevent unnecessary care
  - Must rely on utilization management tools to control service costs
  - Most services are based on face to face visits, and may not include care-coordination and management of conditions by other contact methods
  - As payments are limited to one provider for one interaction, fee for service does little to encourage management of care across settings and among multiple providers
  - Limited to the scope of services offered by a particular agency or independent practitioner
- **Provider**
  - Payment lags service
  - Cost of processing claims, including the losses related to denied claims
  - Losses of flexibility in providing services do to limitations on multiple services on the same day
  - Pressure to maintain high productivity, may lead to practitioner burn out
Episode of Care Payment

- Paying a single price for all services needed by a patient during an entire episode of care (also called case rate)
- Provider has responsibility for the number and types of services provided for an episode
  - Example: if a patient has a heart attack a provider is given a single payment for all care needed by the patient for treatment
- Amount of payment is adjusted for severity
- Providers decide which services are provided within and episode
- Incentivizes eliminating unnecessary care within an episode
- If services of multiple providers are covered by the episode of care payment (bundling) care coordination is encouraged

Bundled Payments

- Single payments for a group of services related to a treatment or condition that may involve multiple providers across varied settings
- Potential to improve coordination across multiple caregivers, provides flexibility in provision of care, incentivizes effective management of episodes
- Limitations include the difficulty in defining an episode, potential barriers to choice of provider, and lack of incentive to reduce unnecessary episodes
On the behavioral health side, this could include paying for facility/hospital not only for the inpatient care but also post discharge service following the discharge from the hospital.

Ideally, this could be at a flat fee for every inpatient stay.

It might also be a bundled payment for providing 6 months of community-based recovery-oriented services for an adult mental health consumer who requires LOCUS Level 3 services.

The provider would need to work with this consumer to develop a recovery oriented professional care plan, a self-care plan and identify a few clinical and personal goals for the consumer.

The provider would also need to measure progress using a validated tool and get high marks on a customer survey.
Pay for Coordination

- Payment for specified care coordination services to specific types of providers
  - Example: medical homes - medical home receives a monthly payment in exchange for the delivery of care coordination services not otherwise provided
- Payment for support services not traditionally covered under a fee-for-service model, and therefore would not be provided
- Potential benefits:
  - Enhanced patient physician communication
  - Enhanced family involvement
  - Improved flexibility for where care can be provided
  - Reduction of unnecessary/inefficient care

Pay for Performance

- Payment or financial incentives for achieving defined and measurable goals related to care processes, and outcomes
- Offers potential to improve quality of care, encourage collaboration, and enhance efficiency of care
- Limitations include single condition focused measures that do not reflect the complexity of caring for patients with complex cases
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Traditional Capitation

- Capitation models are designed to control the number of episodes, as well as the cost of individual episodes
- Provider receives a single payment to cover all services needed by a patient during a set period of time regardless of the number of episodes
- Payment amount is the same no matter how sick or healthy a patient is
- Incentivizes providers to avoid those with chronic or costly conditions

Comprehensive Care/Total Cost of Care Payment

- Involves providing a single risk-adjusted payment for the full range of health care services needed by a specified group of people for a fixed period of time
  - Example: Per Member Per Month
- Similar to capitation, however there are additional risk adjustment methodologies utilized, limits on risk exposure, and incorporation of quality measures
- Benefits include flexibility for providers in terms of care delivery, incentive for efficient care, and improved emphasis on maximizing health
- Limitations include decrease in patient choice of provider, at risk structure for involved entities, and geographic challenges for the provision of care
Wrapping up….

- Alternative Reimbursement Methodologies are just one tool for managing risk
- The risks of adopting an alternative reimbursement methodology must be understood by the MCO and the Provider
- Monitoring tools must be predetermined and part of the implementation process
- A formal evaluation process is an important element of the plan

Questions?