ALTERNATIVE REIMBURSEMENT MODELS

A Practical How-To Guide

November 26 & Dec. 3, 2018
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Expertise

- Strategic planning and metrics-based management
- Managed care and value-based contracting
- Provider/payer relations and network development
- Integrated care model development and implementation

Career Highlights

- Senior Vice President, Network Strategy, Optum/United Health Group
- Executive Vice President, National Network Operations, ValueOptions (now Beacon Options)
- Chief Operating Officer, ValueOptions, Health Plan Divsion
- Director for Quality, Binghamton Psychiatric Center, Office of Mental Health, New York

Agenda

Part 1
November 26, 2018; 1-3pm

1:00-1:15 PM	I. Learning Objectives
1:15- 2:00 PM	II. Overview Of Reimbursement Models: Pros & Cons
2:00-2:30 PM	III. Best Practices & Lessons Learned
2:30-3:00PM	IV. Q&A

Part 2
December 3, 2018; 1-3pm

1:00-1:15 PM	V. Quick Recap of Part 1
1:15-2:00 PM	VI. Success Factors & Case Studies
2:00-2:30 PM	VII. Practicum – How To Walk Through The 10 Steps Of VBR With A Payer
2:30-3:00PM	VIII. Q&A

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Part I

Learning Objectives

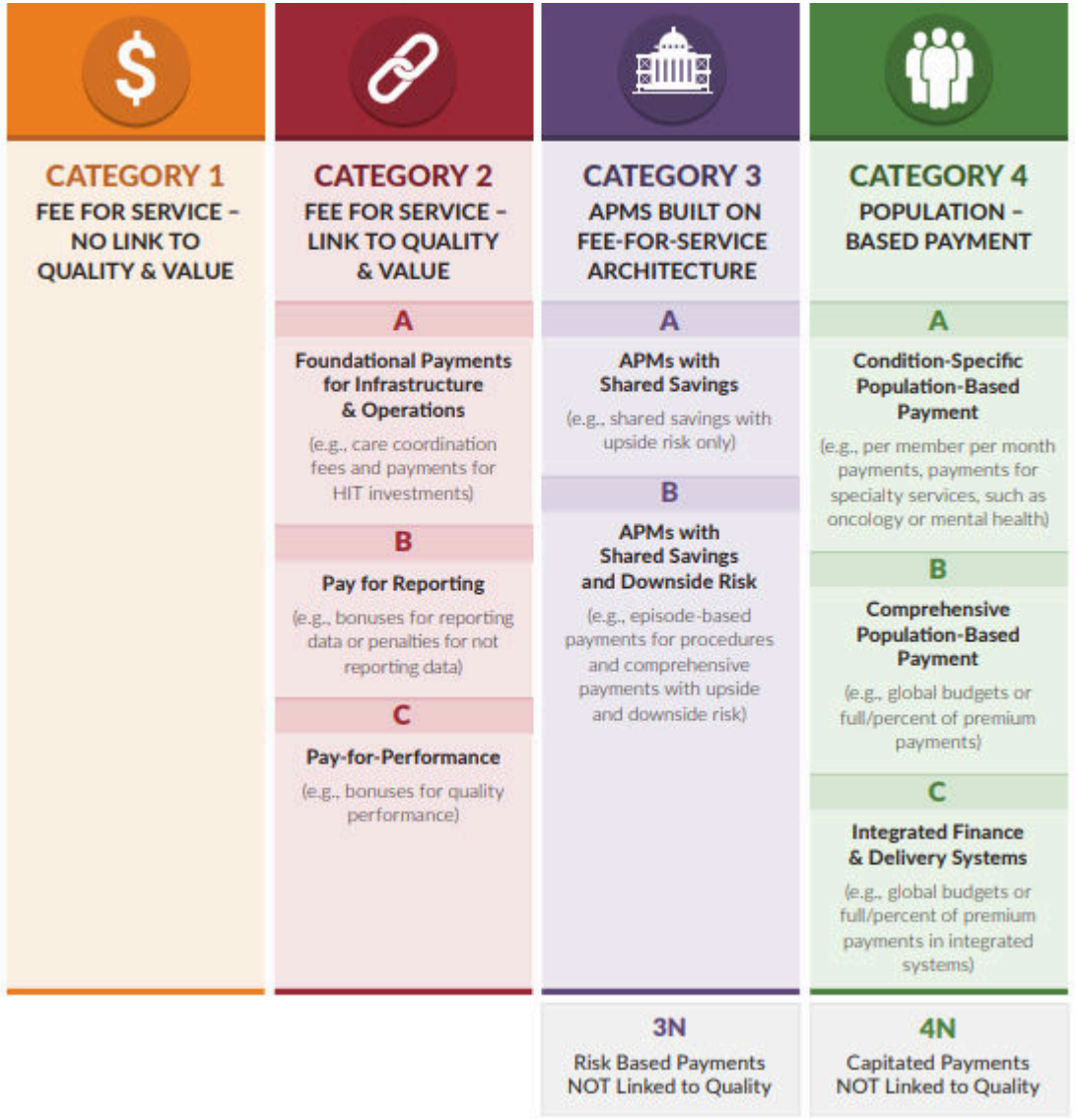
1. **Understand**
   Understand the types of alternative reimbursement models available, pro's and cons to each, and learn the practical "how to's"
2. **Explain**
   Explain the 10 steps to take to develop a successful value-based reimbursement (VBR)
3. **Identify**
   Identify how to overcome common barriers to successful VBRs, including how to work with payers
4. **Describe**
   Describe lessons learned and best practices, including case studies

Overview of Reimbursement Models

Pros & Cons

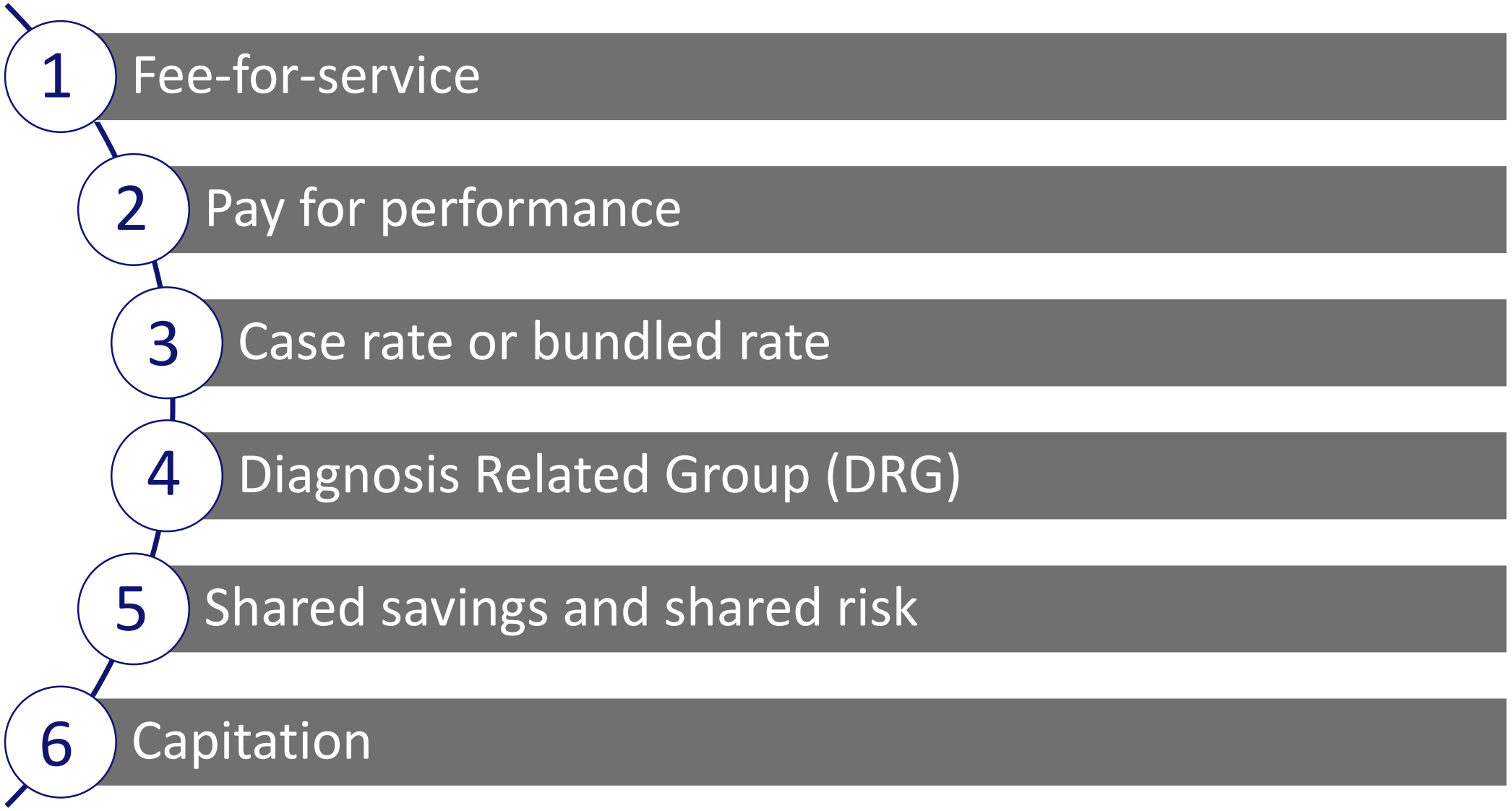
Reimbursement Moving From Volume To Value

This Framework represents payments from public and private payers to provider organizations (including payments between the payment and delivery arms of highly integrated health systems). It is designed to accommodate payments in multiple categories that are made by a single payer, as well as single provider organizations that receive payments in different categories—potentially from the same payer. Although payments will be classified in discrete categories, the Framework captures a continuum of clinical and financial risk for provider organizations.



http://hcp-lan.org/workproducts/apm-framework-onepager.pdf

Reimbursement Types



Reimbursement Types: Fee-For-Service (FFS)

Definition: Separate payment to a health care provider for each unbundled medical service rendered to a patient

Pros

- Payments match services
- Complete utilization data
- More transparency
- Provides audit trail

Cons

- Incentivizes over utilization
- Rigid and stands in the way of innovation
- Discourages efficiencies of integrated care

FFS Example

- "ABC" Health Plan pays a flat rate of $110 for CPT 90791 for a qualified, credentialed, independent licensed provider
- "XYZ" Heath Plan pays a flat rate of $750 for Rev code 124 for acute inpatient level of care after approved authorization

Reimbursement Types: Pay For Performance

Definition: Providers are financially rewarded for meeting pre-established targets for delivery of healthcare services

Pros

- Incentivizes behavior change
- Lead to improvement of quality measures
- Encourage more efficient coordination

Cons

- Provider only focused on care that affects measures, and ignore other factors - “manage to metric” or “cherry pick” member
- Incentive may not be large enough to promote behavior change
- Provider could see overall reduction in revenue if unable to fill vacancy
- Difficult to evaluate causality v. random fluctuation

Pay For Performance Example

- “ABC” Health Plan pays an escalator of up to 6% for rev code 124 (acute inpatient level of care) based on achievement of HEDIS 7-day ambulatory follow up
- “ABC” Plan pays a 1 time bonus of $50,000 for achievement of key performance measures included assuring consumer compliance with annual dentist visit

Reimbursement Types: Case Rate or Bundled Rate

Definition: A flat payment for a group of procedures and/or services

Pros

- May decrease need for authorization and concurrent review
- Controls cost per episode
- Incentivizes fewer re-admissions
- Can bundle multiple services and promote innovation

Cons

- Incentivizes shifting treatment to other settings or codes
- Increase oversight to manage quality
- Increases risk to providers
- Potential for double payment if member switches provider
- Encourages discharge once member passes breakeven point
- Incentivizes admissions
- Need to make many assumptions, e.g.. service mix, license mix, etc
- Requires system to support

Case Rate Or Bundle Rate Example

- "ABC" Health Plan pays a monthly rate of $1,200 for Medication Assisted Treatment (MAT) to include medication management, counseling services, and lab services associated with treatment, excluding medication costs
- "XYZ" Health Plan pays a case rate of $7,000 for acute inpatient episode to include all services (e.g., physician fees, labs, etc.) for a single treatment episode. A readmission warranty includes a 10% withhold for any case that is readmitted within 90 days of treatment
- "EFG" Health Plan pays a tiered case rate of $800 for day 1 of treatment, $600 for days 3-5, and $200 for Days 6 and 7 with no payment after day 7 for acute inpatient treatment

Reimbursement Types: Diagnosis Related Group (DRG)

Definition: A flat payment for a bundled group of procedures and/or services that are needed to treat a particular disease

Pros

- Single predictable payment allows provider to manage services
- Generally state of CMS-defined

Cons

- May not include outlier protocols for complex cases
- May be more medically driven
- May focus scrutiny on admission approval

DRG Example

- "ABC" Health Plan pays 100% of the state-defined DRG with no outlier methodology.

Reimbursement Types: Shared Services & Shared Risk

Definition: Provider and payer share in the healthcare savings pool generated by performance improvement (e.g., reduced behavioral costs or total cost of care)

Pros

- Offer a reward split among those contributing to the success (e.g., payer supports analytics and member assignment and provider implements interventions to reduce costs
- Shared risk is a variation in which the provider is "at risk" for the service costs
- Good step toward capitation if successful

Cons

- "Shared" is not always a 50/50 share
- Achievement may result in little room for ongoing improvement—need to develop go-forward model of sustainability

Shared Savings & Shared Risk Example

- A Core Service Agency (CSA) offers a full continuum of care and has been assigned 500 seriously and emotionally disturbed (SED) children to manage with a goal of improving community tenure and reducing out-of-state foster care placement. Achievement of pre-defined target measures (using baseline year of data) will result in the Plan and the CSA splitting the savings (generated from reduced higher level of care costs) 50/50
- Variation – CSA is at risk for the membership and splits any achievement with the Plan, but must pay all services and provide transparency into service utilization and costs

Reimbursement Types: Capitation

Definition: A set payment for each enrolled person assigned to that physician or group of physicians, whether or not that person seeks care, per period of time

Pros

- Rewards groups, and in turn those groups' individual physicians, who deliver cost-efficient care
- Costs stable and predictable
- No billing

Cons

- Assignment can be challenging in behavioral health environment
- Payers concerned that under-treatment might occur
- Dependent on marketplace factors and a group's negotiating power
- May result in increased oversight by payer
- Regulatory hurdles
- Requires system to support

Capitation Example

- An outpatient provider is paid a per member per month (PMPM) to support the care coordination of an assigned cohort of 500 individuals that meet the state definition of severe and persistently mentally ill (SPMI). The provider can earn a bonus on top of the PMPM if key performance measures are achieved.

Key Components Of Performance-Based Contracts

Entry Level Criteria

- Submit claims electronically with fast turn around time and/or have data sharing capabilities
- Participate in review and intervention discussion (e.g. once a month)
- Adhere to current managed care requirements and clinical guidelines

Measures

- Balance of Quality and Cost/Efficiency Measures with Social Determinants of Health tracking
- Emphasis on outcome vs treatment process measures
- Examples: PCP visit in past 12 months, #/% employed in integrated program, wages earned over 2 week in paid community job, national core indicators (NCI)

Rewards

- Annual escalator
- Bonus payment
- Prorated based on performance to capped amount

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Most Commonly Used Performance Measures Of Specialty Provider Organizations, 2016-2018

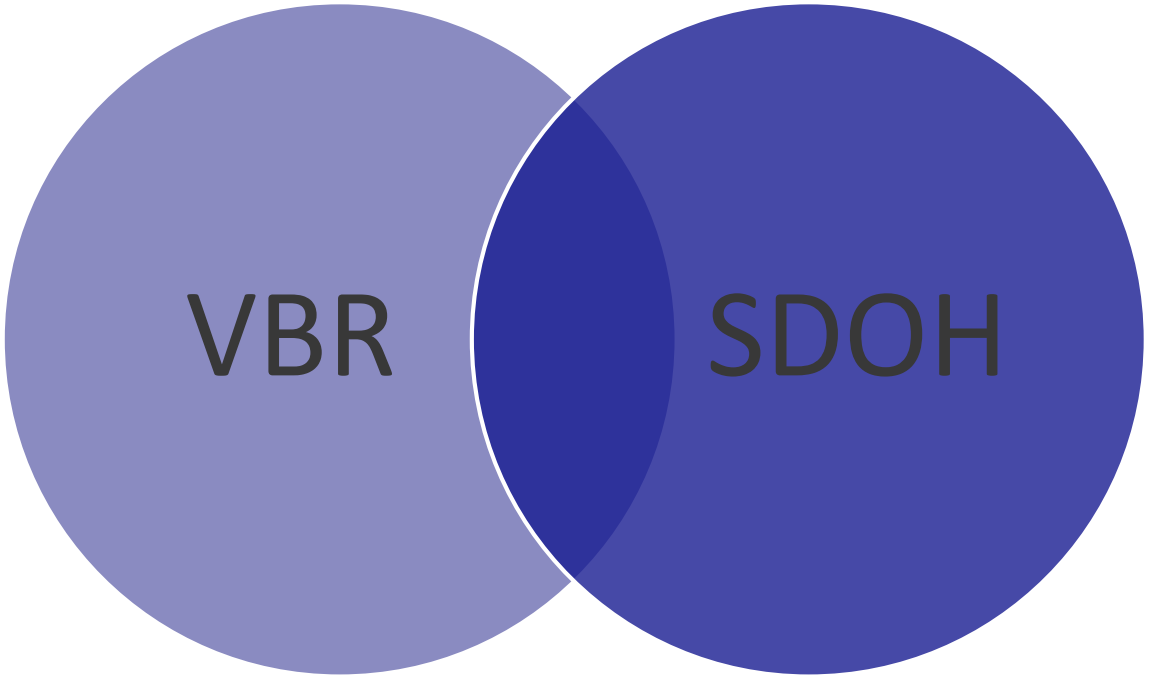
- Follow-up after hospitalization for mental illness
- Emergency room utilization
- Readmission rates
- Patient or consumer satisfaction
- PCP Engagement
- Access to care measures
- Diabetes screening for people with Schizophrenia using an antipsychotic
- Antidepressant medication management
- Community Tenure
- Depression monitoring via PHQ-9
- Patient Reported Outcomes
- Involvement of family/significant other
- Initiation/ engagement of alcohol and other drugs
- Diabetes care – blood sugar controlled
- Adherence to antipsychotic medication for people with schizophrenia
- Use of depression screening and follow-up
- Risk adjusted ALOS

The Intersection Of Value-Based Reimbursement (VBR) & Social Determinants Of Health (SDOH)

VBR

Ties reimbursement to quality and efficiency measures

- Facilitates the achievement of the triple aim—improving population health, reducing the costs of health care and improving individual member outcomes
- Supports provider engagement and payer/provider collaboration
- Rewards provider performance on agreed upon measures of quality and utilization

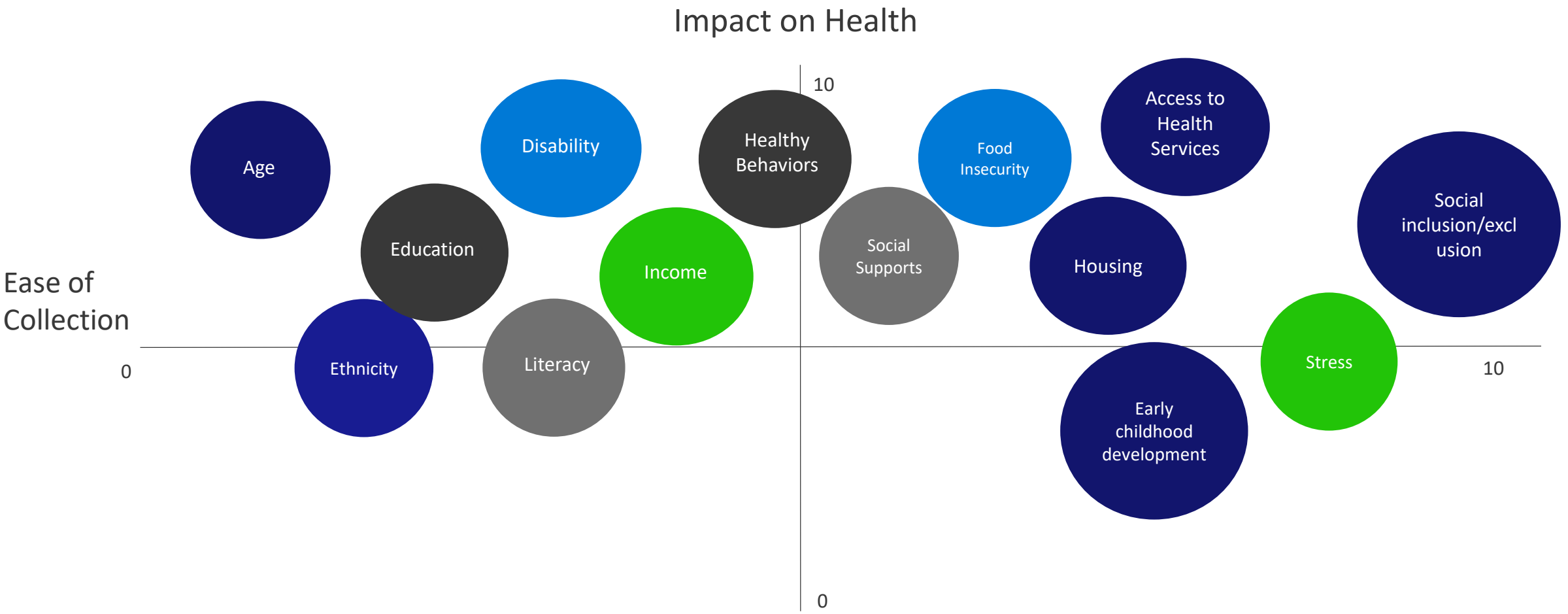


SDOH

Environmental factors that influence a population's health and functioning (e.g., socio-economic status, transportation, age)

- Provide important detail that can guide interventions to achieve VBR goals
- Increase understanding of population needs
- Move VBR beyond easy-to-access measures that hold greater meaning

Population Health Drivers



What is the return on investment in collecting social determinants of health?

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Best Practices & Lessons Learned

Why Value-Based Reimbursement Fails

Organization lacking:

- Review and collaboration around results
- Development of targeted interventions
- Visibility to key stakeholders
- Population of focus is unclearly defined

Example:

- No meetings to review scorecards/email distribution
- Interventions lacking – not developed or not monitored
- Results not cascaded to key decisionmakers and action takers
- Lack of understanding of population characteristics and social determinants of health

How Value-Based Reimbursement Succeeds

Organization has:

- Population cohort clearly defined
- Regularly monthly meetings to review results at the case level with decisionmakers, key stakeholders, and action takers
- Interventions developed with close monitoring of follow-through and impact on results

Example:

- Individuals meeting state definition of seriously and persistently mentally ill (SPMI) with collection of social determinants of health to include developmental delays, caregiver supports (e.g., transportation, respite), etc.

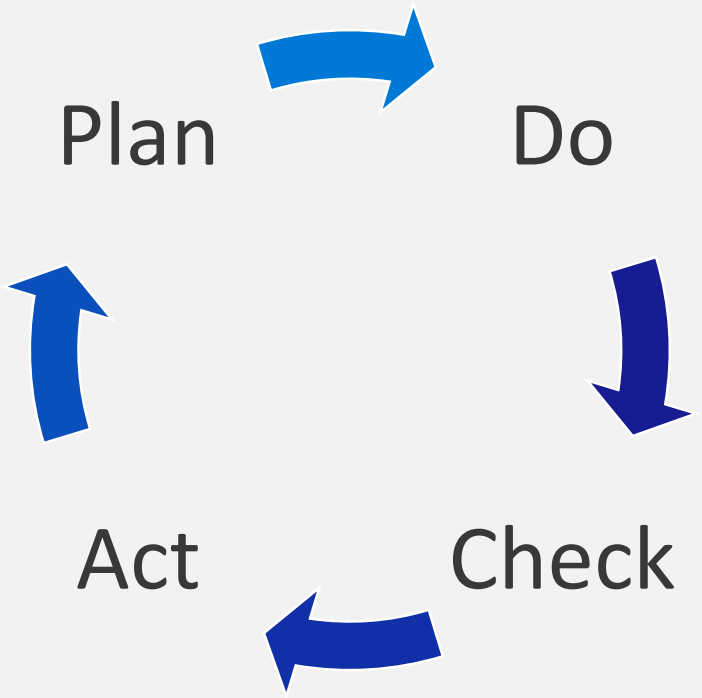
Findings: Consumer with the least progress on the quality and utilization outcomes measures were those with co-morbid developmental delays and behavioral health needs. Gaps in care including respite services, transportation and services for those with dual diagnoses were tackled as part of the actions taken through joint efforts by the payer and provider team.

How To Overcome Some Of The Pitfalls Of VBR Failures

- Get Payer **Buy-in**
- **Leverage** Electronic Health Record (EHR)
- **Engage** the right stakeholders
- Design interventions with those closest to the process with **visibility** to key leaders

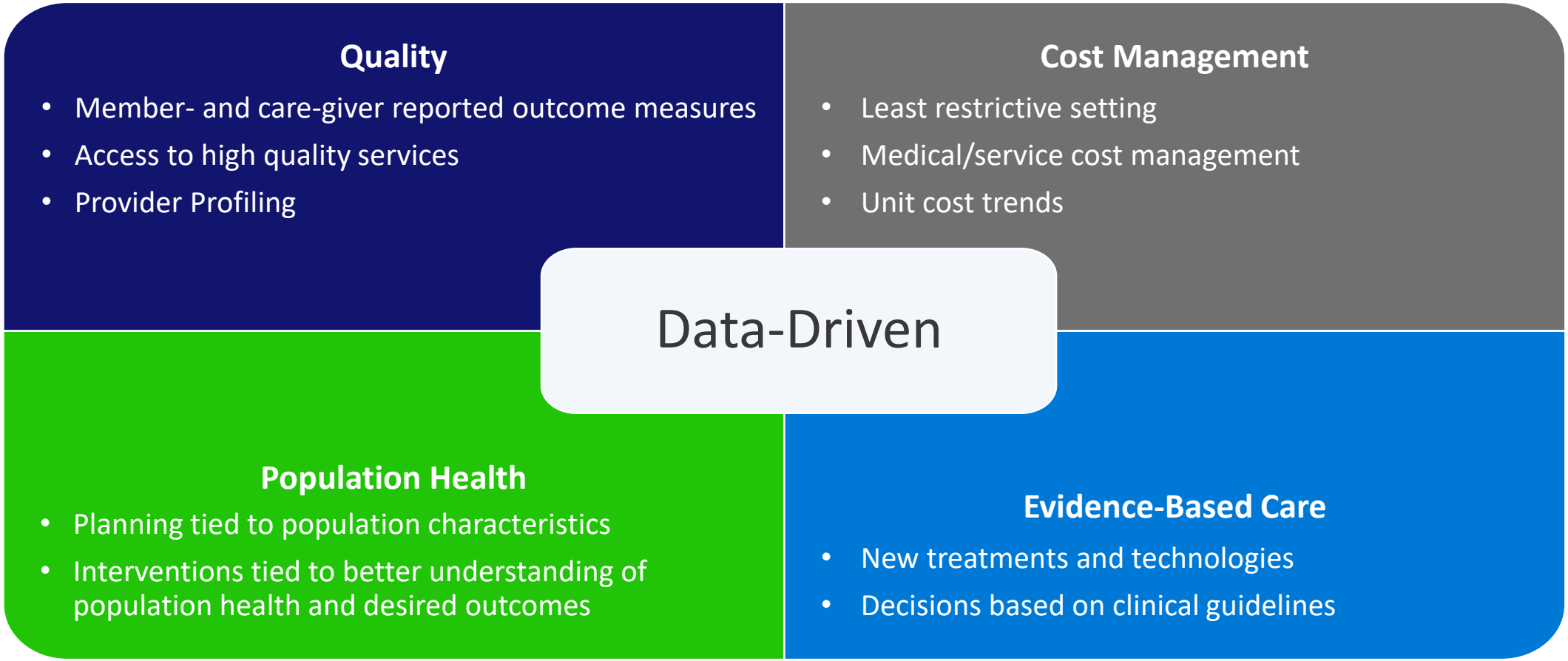
Value-Based Reimbursement Checklist

- **Gather** the right team
- **Define** the goal (e.g., reduce out-of-state placement for foster care)
- **Establish** the metrics – both quality and utilization management with clear definitions and design the data collection process to include both measures of performance success and population health characteristics confirm
- **Approach** payer with clear, succinct proposal that includes financial model and anticipated return on investment
- **Develop** regular structure for reporting (e.g., scorecards), monitoring and evaluation to include intervention development
- **Collect** and analyze data.
- **Develop** interventions based on analysis.
- **Monitor** intervention impact.
- **Review** interventions based on outcomes.
- **Maintain** monitoring and evaluation efforts.



Managed Care Principles & Implications To Value-Based Reimbursement

Managed Care Principles



ACCESS, COST, QUALITY

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Triple Aim

Managed care and providers agree on the Triple Aim.

- High quality services in the least restrictive setting
- Broad system of services, including natural supports
- Consumers are empowered and engaged

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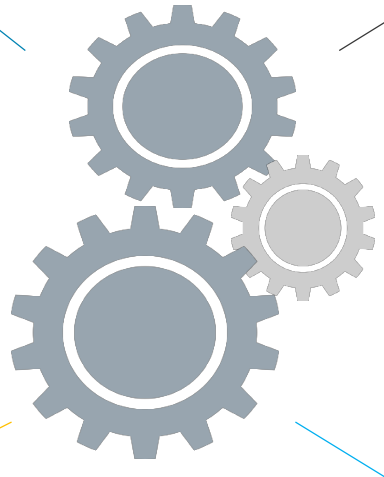
Tools to Improve Quality & Cost Outcomes

Provider-Focused Tools

- High-performance networks and providers, including Centers of excellence
- Delivery system innovation, such as patient-centered medical homes and accountable care organizations (ACOs)
- Electronic medical records (EHRs), apply population health characteristics
- Information exchanges and learning collaboratives
- Pre-service / concurrent / retrospective review and physician education
- Outpatient, inpatient, and pharmacy utilization review
- Provider performance measurement and quality improvement programs
- Value-based provider payments

Member-Focused Tools

- Health and wellness programs
- Case management
- Disease or condition management
- Care coordination
- Transparency re: provider performance
- Consumer-directed incentives for healthier behavior
- Value-based benefits, including tiered benefit and rewards to seek services with high value providers



Core Tools

- Benefit plan design
- Medical necessity clinical guidelines and medical/service policies
- Coverage determination guidelines
- Appeals and grievances for members and for providers
- Technology assessment

Provider & Member-Focused Tools

- Health care information technology
- Sophisticated clinical analytics to identify gaps in care and in affordability
- Collaborative measurement projects, using multi-payer claims databases
- Administrative simplification through automation

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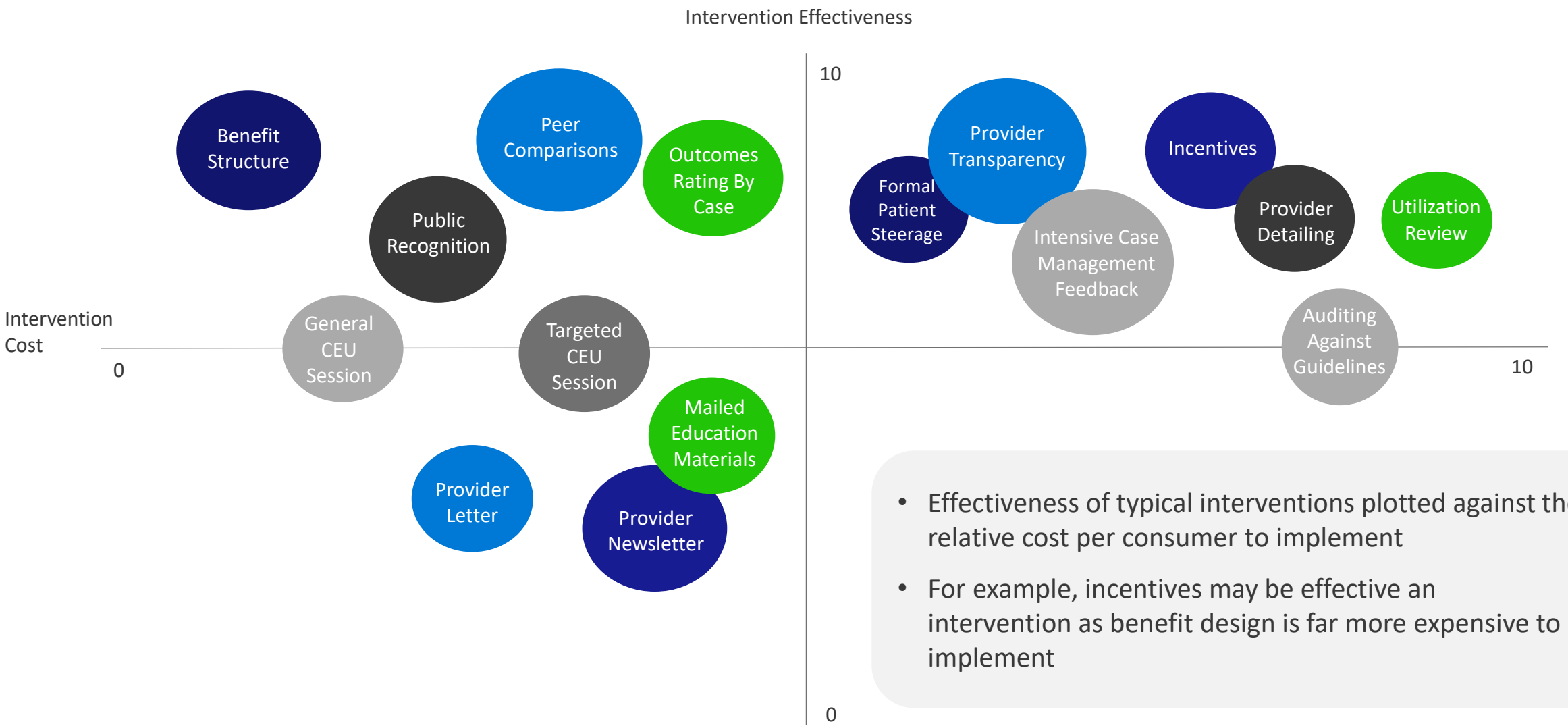
Cost/Effectiveness Analysis of MCO Interventions



- Effectiveness of typical interventions plotted against the relative cost per consumer to implement
- For example, incentives may be effective an intervention as benefit design is far more expensive to implement

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Strategic Implications Of Managed Care Principles

Develop positive payor relationships

Evaluate measure collection and analysis against measures expected by payors/state

Understand unit costs and improvement opportunities

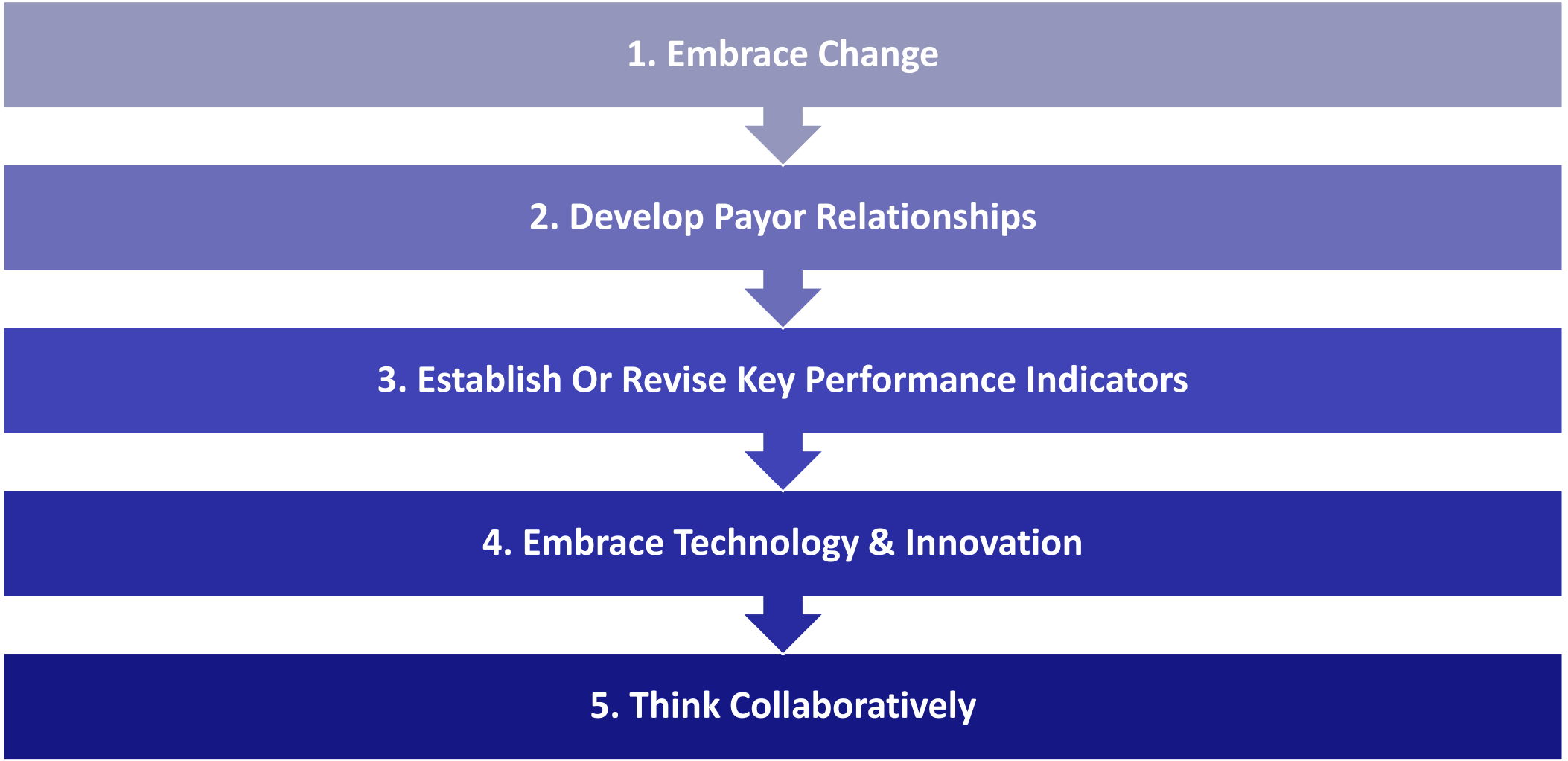
Review current workflows against managed care requirements (e.g., authorization rules, reports)

Q&A

Part II

Success Factors & Case Studies

Managed Care Principles



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Success Factor #1: Embrace Change

Key Principles

1. Be a change leader; create a culture that is able to flex and rewards flexibility.
2. Address both the rational reason for the change and the emotional case - what's in it for me (WIFM).
3. Assess and communicate, communicate, communicate.
4. Start at the top but involve every mind.
5. Identify and celebrate small wins; break the change into smaller components.
6. Celebrate success!

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Success Factor #2: Develop Payor Relationships – $P^3=W^3$

- Know what the payer needs and wants.
- Get to know key payer leaders/decision makers on a personal level.
- Pitch a pilot that resonates with the payer's needs and the provider organization's needs - Payer/Provider Pilot.

- Community Mental Health Center (CMHC) and payer concerned about medication adherence of high risk members
- Engaged vendor who specialized in co-located pharmacies that offer specialized adherence packaging, consults, alerts, member education, refill reminders, and reporting
- RESULT: $58 PMPM savings; Incentive payment for the CHMC.

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Success Factor #3: Establish Or Revise Key Performance Indicators

Follow-up after hospitalization	Emergency room utilization	Readmission rates	Consumer & caregiver satisfaction
Use of evidence-based care protocols	Access to services measures	Diabetes screening	Medication Adherence
Appropriate referrals to other providers	Depression monitoring via PHQ-9	Consumer employment	Involvement of family/significant other
Annual eye exam	Consumer reported health measures	Annual Dentist Visit	Annual Physical (PCP engagement)

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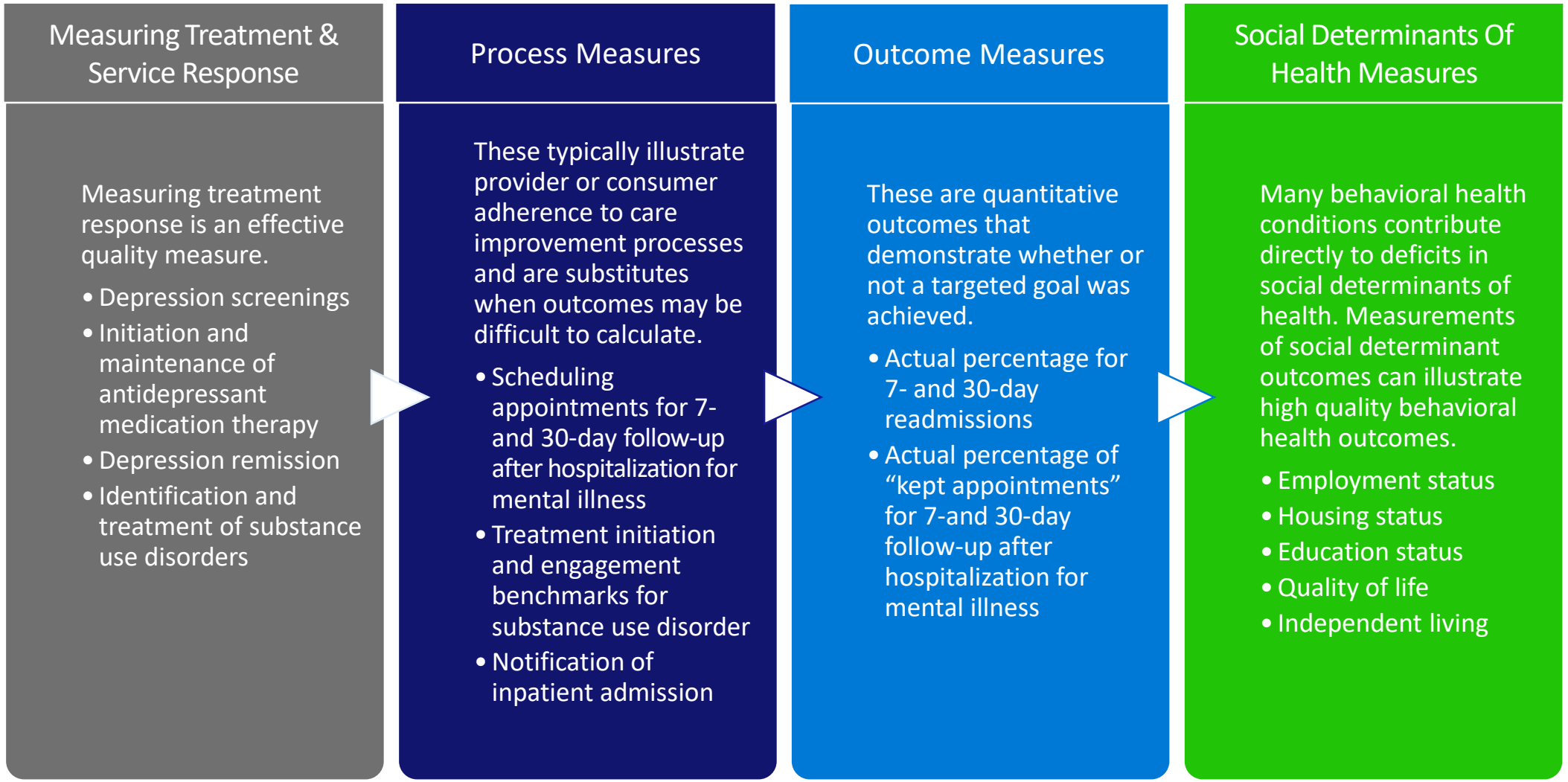
Defining Outcomes: Measure Performance With Defined Outcomes



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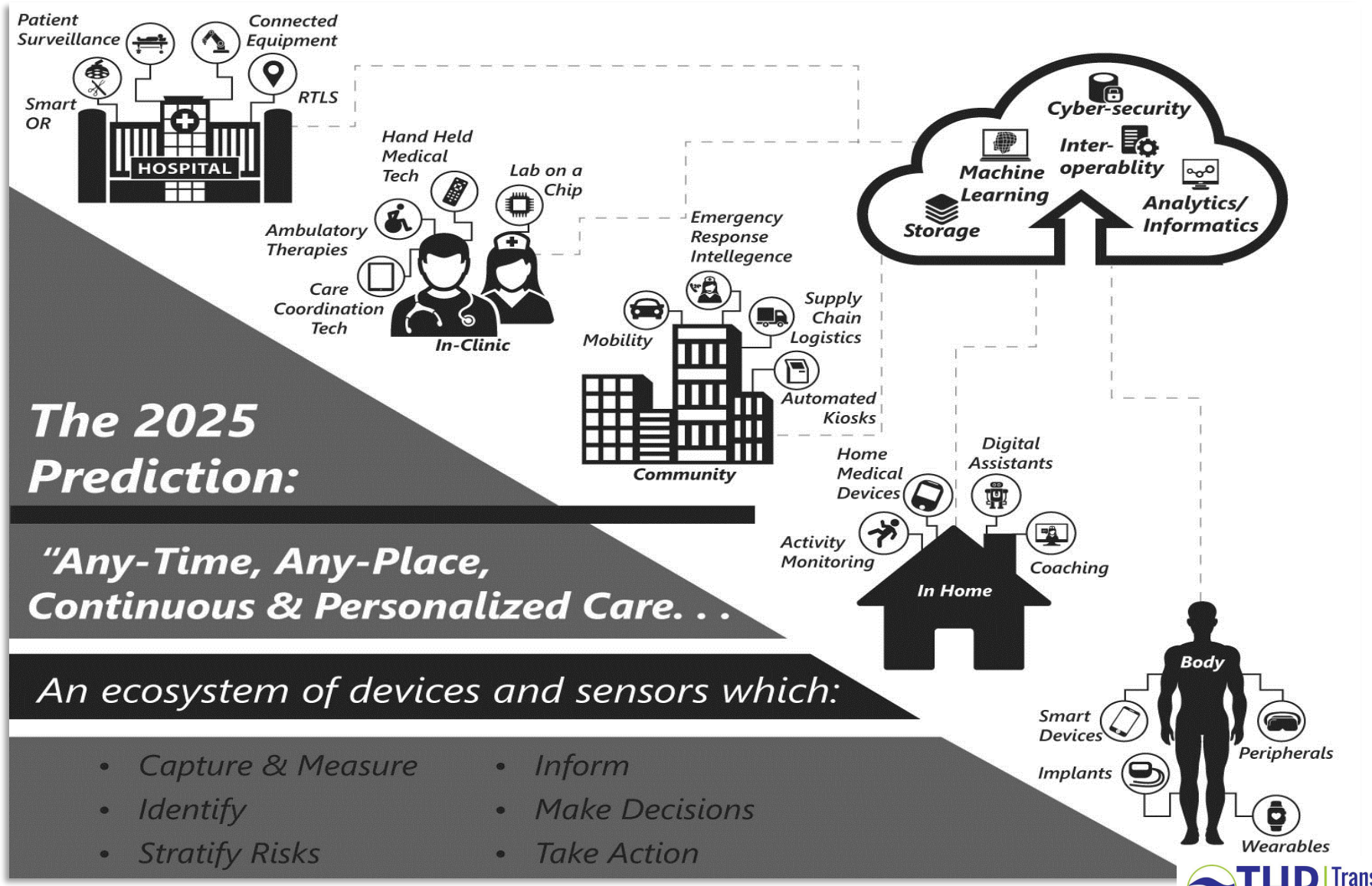
Success Factor #4: Embrace Technology & Innovation



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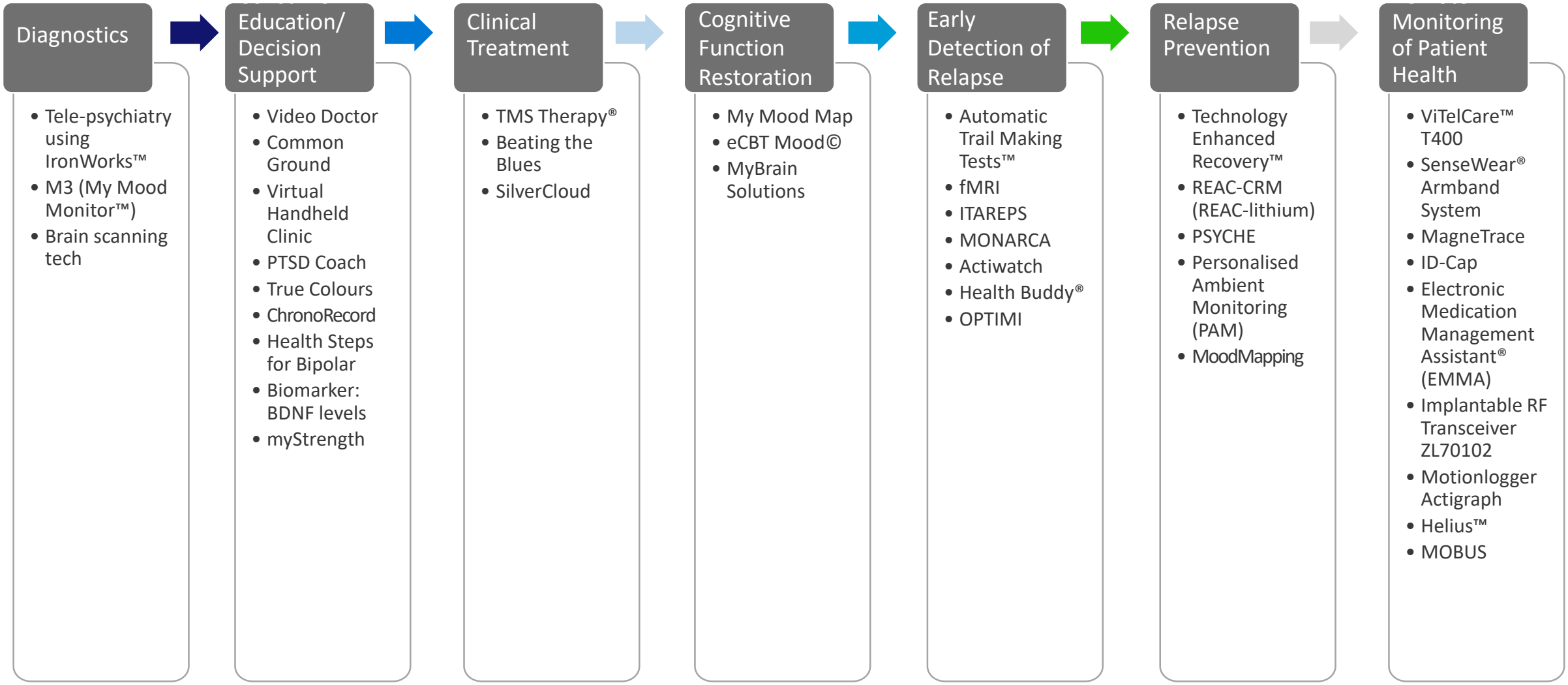
Success Factor #4: Treatment-Enabling Technologies Available All Along The Service Continuum



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Success Factor #4: The Human Support Factor

Coach-supported web-based interventions

- Are effective (ds=.56 – 1.08)
- Patients are adherent (~9 logins)

Coaches do not need to be mental health professionals

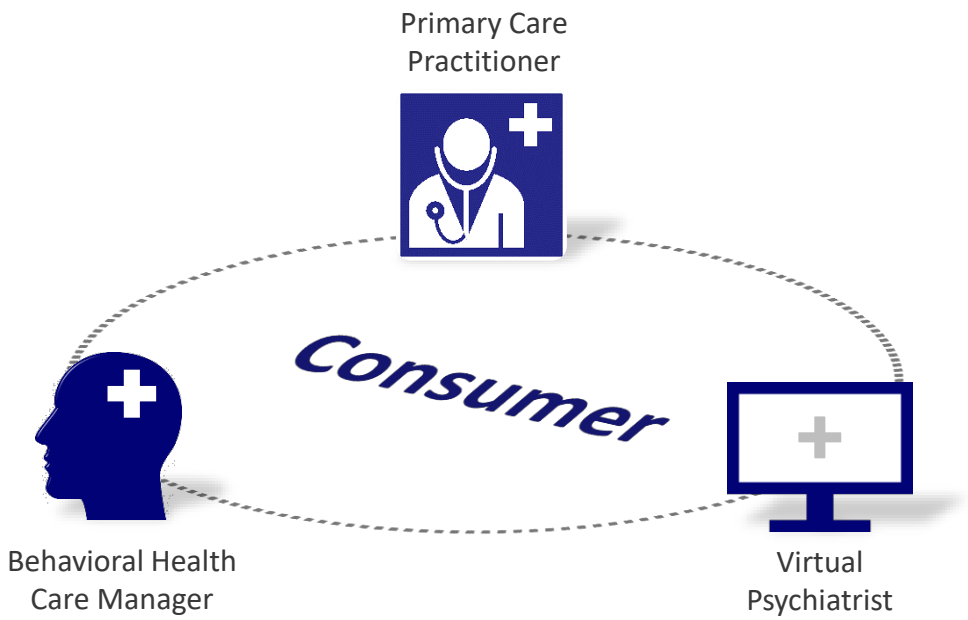
Success Factor #5: Collaborative Care Model (CoCM)

Collaborative Care Model (CoCM)

Rewards PCP and multi-disciplinary treatment team to screen members for anxiety and depression

Virtual psychiatrist provides consultation to PCP for complex cases

Embedded care manager coordinates care and updates data register



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Mental Health Case Study

Entry Level Criteria

- CMHC agrees to participate in monthly score card review
- Coordinate with Primary Care Physician (PCP) and other specialty providers to support medical Healthcare Effectiveness Data and Information Set (HEDIS) measure improvement (e.g. Dental appointments)
- Support collaborative care model by offering care coordination support and/or virtual prescriber access

Measures

- Follow up within 7 days post inpatient discharge and 7 days post Emergency Room (ER) visit.
- Diabetes screening
- Community tenure

Rewards

- PMPM bonus payment prorated by outcome results

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Mental Health Case Study

Entry Level Criteria

- CMHC, Pharmacy programs agree to report measures and meet monthly to review scorecard and implement intervention
- Agreed upon roles and responsibilities regarding consumer engagement workflows

Measures

- Rx adherence measures by percentages of days covered for anti-psychotic medication
- Rx adherence measures by percentages of days covered for anti-depressant medication
- Rx adherence measures by percentages of days covered for diabetes medication
- Rx adherence measures by percentages of days covered for hypertension medication
- Medication gaps

Rewards

- PMPM bonus payment prorated by outcome results

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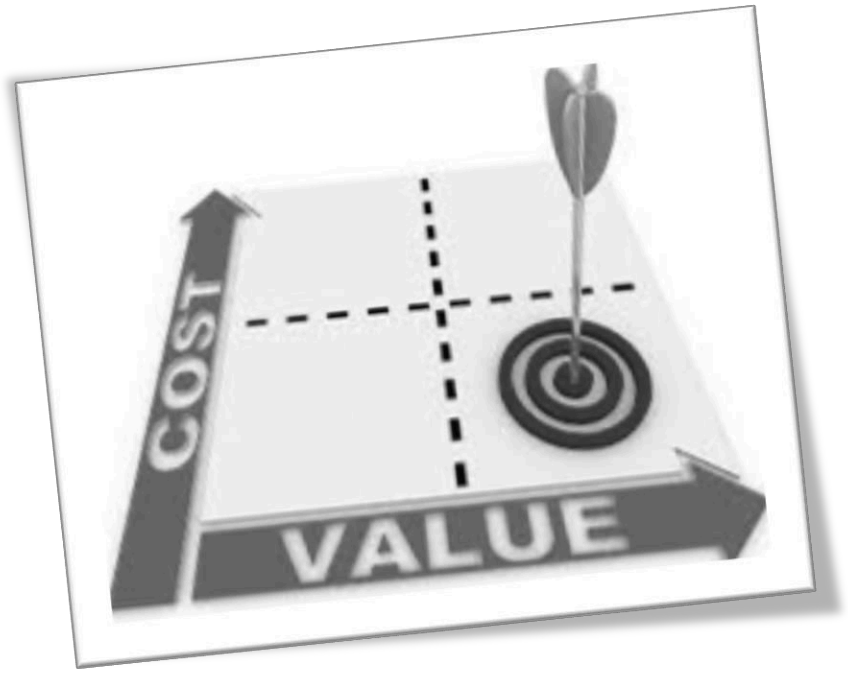
All Types of Services Moving to Pay-for-Value

Pay-for-value changes the rules for service reimbursement – and opens up opportunities for leveraging new science and technology to reduce costs and improve consumer convenience.



- Specialty medical homes for consumers with serious mental illness (SMI), addictions, traumatic brain injury (TBI), Alzheimer's, and chronic health conditions – with all care coordination services paid in per member per month (PMPM) payment
- Capitated contracts for Intellectual and Developmental Disabilities (I/DD) services – Kansas Medicaid and 18 other states to follow
- Capitated contracts for senior services (including nursing home care) planned for 19 state Medicaid plans
- Case rates for children's services in child welfare system
- Case rates for TBI support services
- Voluntary self-directed I/DD services with individuals consumer budgets launching in California

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Practicum

How To Walk Through The 10 Steps Of VBR With A Payer

The 10 Steps of VBR with a Payer

The Value-Based Reimbursement Checklist

The Value Based Reimbursement Checklist

Step 1: Assemble the Team

Include leadership for awareness and those directly engaged in implementation and monitoring

CFO:	Name	**Clinical Leader:**	Name
CEO:	Name	**Billing:**	Name
COO:	Name	**Team/Unit Leaders:**	Name
Data/Reporting/Analytic Support:	Name	**Others** (Direct control over implementation of intervention or vested interest)	Name(s)

Example: A residential program seeking a VBC arrangement involved for awareness and buy in- CEO, COO, and clinical leaders. Payer Relations & Finance Leader coordinated contract with payer review and approval of CFO/CEO. Achieving VBR reward required workflow changes and technology changes which required engagement of care team across all shifts; CTO to support availability of technology and discharge planner.

The Value Based Reimbursement Checklist

Step 2: Define the Goal

Example:

a. Reduce out-of-state placement for foster care
b. Increase community tenure
c. Improve consumer reported health & wellness
d. Reduce readmissions
e. Improve medication adherence

Goal

Text here

The Value Based Reimbursement Checklist

Step 3: Determine Metrics

a. Balance of Quality & Efficiency metrics
b. Obtain payer and/or State feedback/input
    1. What measures is the State/Payer endorsing or incentivizing
    2. What pain points exist for payer/state client
    3. Consider social determinants of health (SDOH)

Metrics List	Determine data definition and collection route
Quality:	Quality:
Efficiency:	Efficiency:
SDOH:	SDOH:

Example:
State offers incentive to improve 7 day follow up and PCP engagement. MBHO is missing targets on these measures.

Quality:

a) Consumer participates in annual PCP visit.
b) Consumer health outcome score improves on SF-12. change pre and post.

Efficiency:

a) Community tenure

Source:

a) Health plan claims
b) SF-12 collected by case based 12 months prior and 12 months post program engagement

Efficiency:

a) HP Claims

The Value Based Reimbursement Checklist

Step 4: Approach Payer With Proposal, Metrics, Financial Arrangement

Meet with Payer

1. Reach as high into organization as possible – C-Suite
2. Learn payer pain points and objectives
3. Identify payer preferred provider programs
4. Seek congruence across payers

Pitch the Idea

1. Keep proposal succinct – goal. measurable, objective, planned activities, return on investment
2. Illustrate this is a "win-win-win" for the payer, provider, and consumer
3. Find the WIFM (What's in it for me?)

Do Unit Cost Homework

1. Map activities and processes
2. Determine cost of each activity process
3. Determine service level unit costs
    - Costs per case
    - Understand drivers of cost variation
    - Cost per diagnosis and clinical path
    - Population cost distribution

Finalize the Financial Arrangement

1. Consider an upside pay for performance as a 1st step (e.g. bonus for achieving outcomes) prorated against achievement
2. Risk share should aim for 50/50 split with estimated return on investment (ROI)
3. Bundle payments may fit if you offer an array of services each month – know your monthly costs.

The Value Based Reimbursement Checklist

Step 5: Develop Reporting Structure

It all starts with Structure

Structure → Process → Outcome

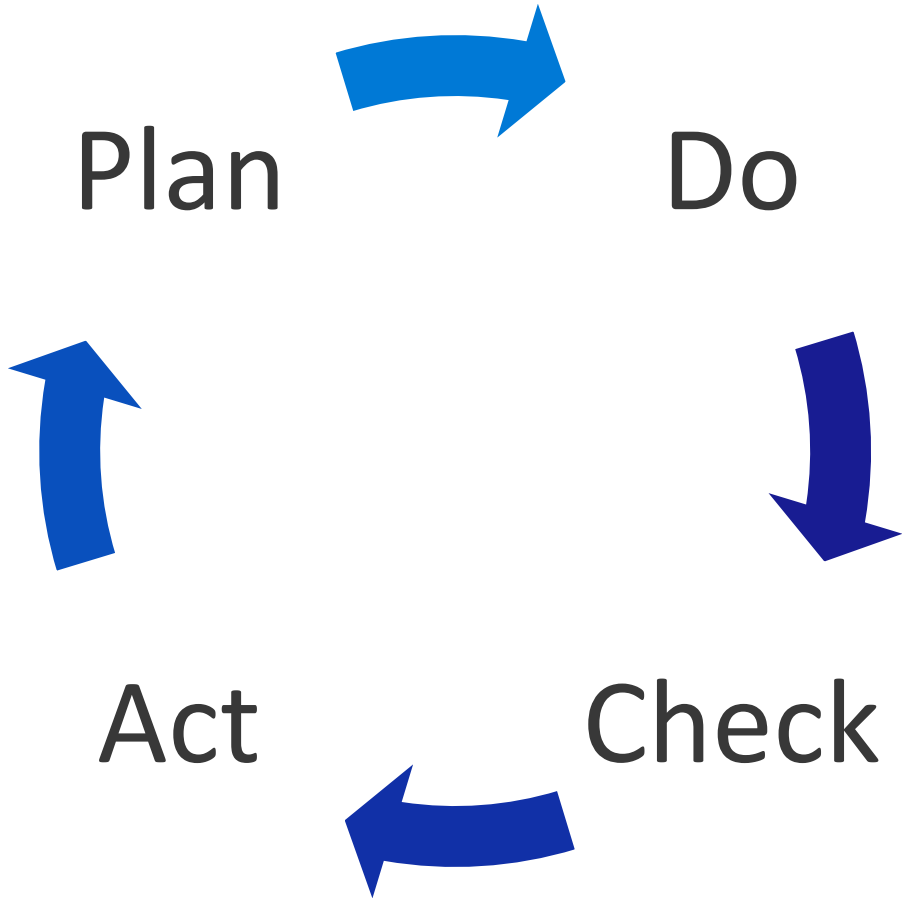
Develop regular structure for reporting (e.g. scorecards), monitoring and evaluation to include intervention development

a. Ideally, know your scores before the payer scorecard is released
b. Review case level detail weekly, monthly, and in aggregate
c. Capture root cause issues and interventions
d. Leverage EHR and SDOH data to avoid spreadsheet rainfall

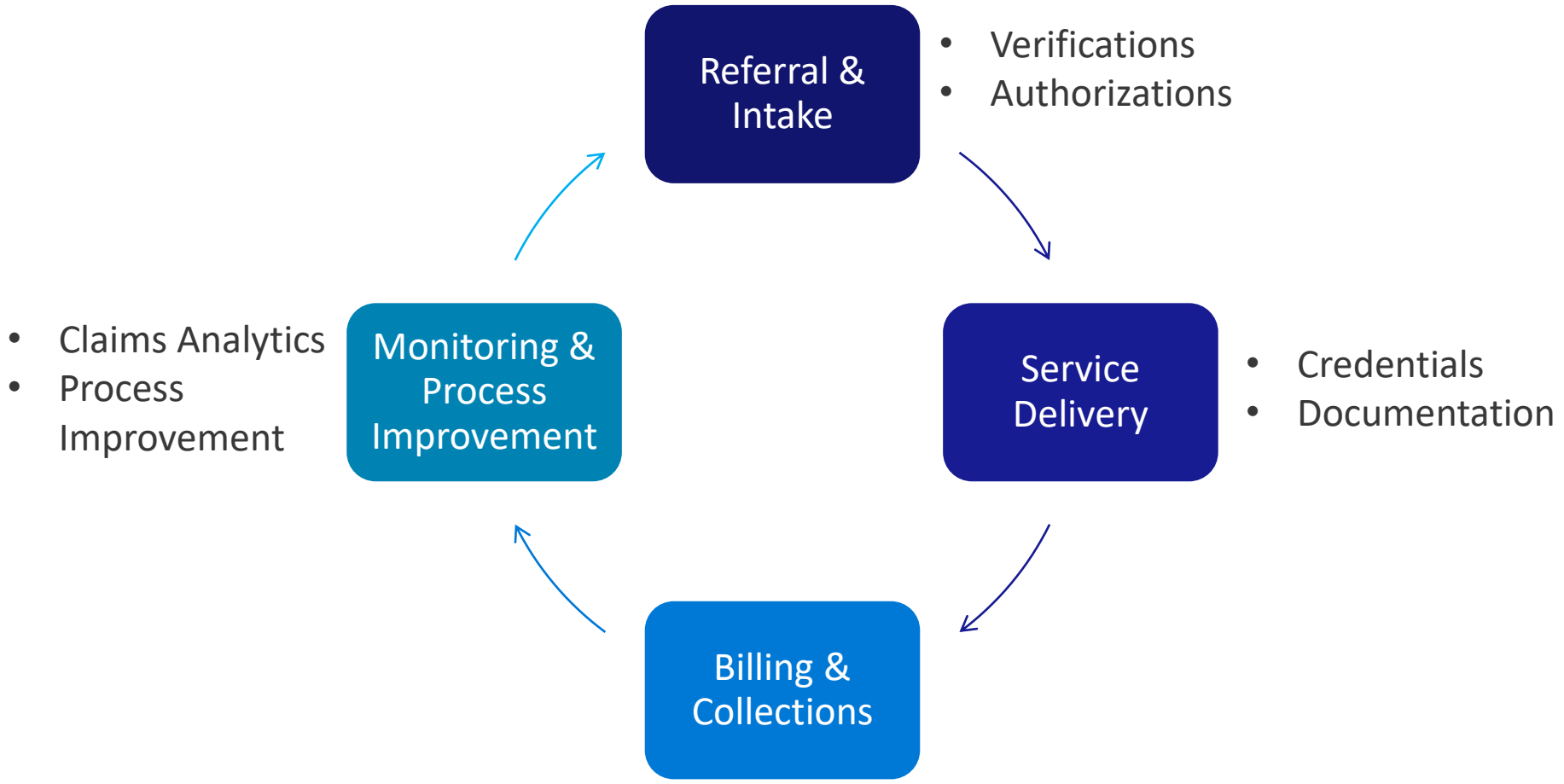
The Value Based Reimbursement Checklist

Step 6-10: Launch

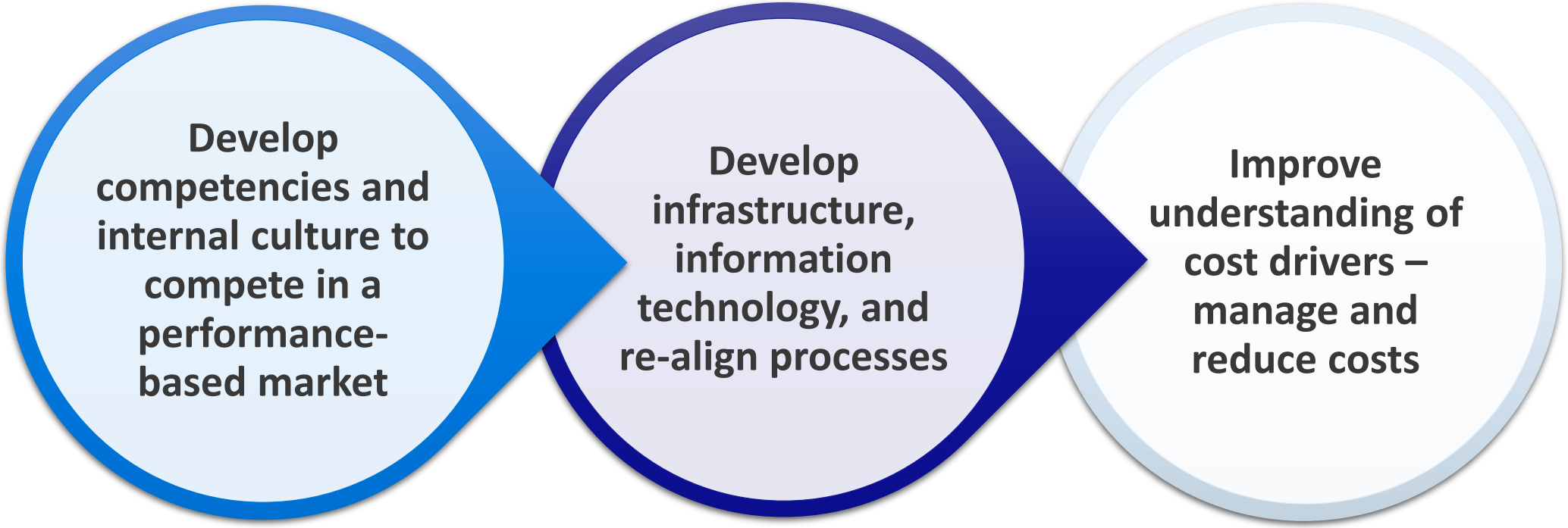
Launch
Collect and analyze data
Develop interventions based on analysis
Monitor intervention impact
Review interventions based on outcomes
Maintain monitoring and evaluation efforts.



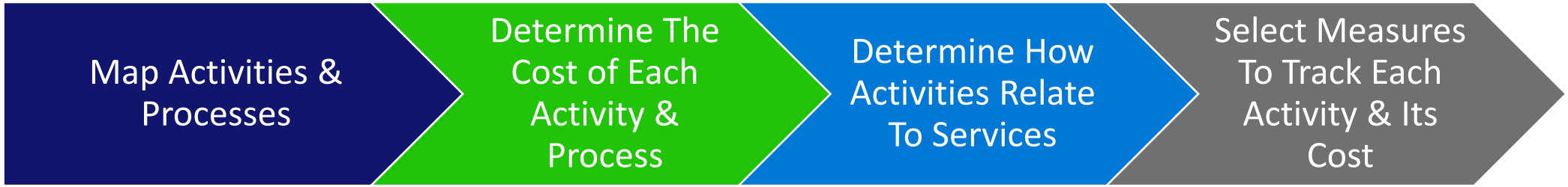
Understand Process Improvement Opportunities



Strategic Financial Implications of Shifting Reimbursement Market



How Does Activity Based Costing Work?



- Determine and manage the cost of services
- Evaluate outsourcing options
- Develop “What if” scenarios for service expansion or reduction
- Assist marketing staff in product design and service pricing
- Develop budgets
- Measure performance
- Evaluate the cost benefits of alliances or mergers

Q&A