Beyond FFS: Like It Or Not, Performance-Based Reimbursement Is Your Future

Session 1: Finding The Competitive Advantage (& Avoiding The Pitfalls) In The New Financing Models

Monica E. Oss, Chief Executive Officer, OPEN MINDS
Agenda

I. Trends In Financing & Reimbursement In The U.S. Health & Human Service System
II. The Move To Performance Measurement – With Transparency
III. The New Reimbursement & Service System Landscape
IV. The Strategic Implications Of The Move Beyond Fee-For-Service – Positioning In The New Environment
Beyond FFS. . .

> The focus is all about the money
> The solution is all about a shift in paradigm
> Done as much cost reduction with FFS reimbursement to provider organizations as possible (including FFS-based managed care)
> “Back to the future”

Question: Can service provider organizations be more successful now?
I. Trends In Financing & Reimbursement In The U.S. Health & Human Service System
The U.S. health and human service system is not functioning effectively. All the ‘easy’ cost savings have been made. Health care reform is eliminating opportunities for cost shifting. New payer focus is on cost of ‘uncoordinated’ care for small proportion of consumers using largest proportion of resources.
The 5% Issue

> 5% of U.S. population—those with most complex medical conditions—account for half (49%) of health care spending

  • Annual medical expenses (exclusive of health insurance premiums) equaled or exceeded $11,487 per person

> 20% of the population accounts for 80% of spending

> 50% of population account for only 3% of spending

  • Annual medical spending below $664 per person
Health Care Expenses By Percentiles of U.S. Population: %, 2002

Percent of Total Expenditures

- Top 1%: 22%
- Top 5%: 49%
- Top 10%: 64%
- Top 20%: 80%
- Top 50%: 97%
- Bottom 50%: 3%
Dual Eligibles Account For More Than A Third Of Medicare & Medicaid Spending

> 21% of 43 million Medicare beneficiaries – account for 36% of all Medicare spending in 2007

> 15% of the total 58.1 million Medicaid beneficiaries — and use 39% of Medicaid resources

Dual eligibles: Consumers eligible for both Medicare and Medicaid based on disability and low income
75% of U.S. Health Care Spending Focused On Chronic Illness

> Services to support chronic illnesses contribute to 75% of the $2 trillion in U.S. annual spending

> Patients with co-morbid chronic conditions costs 7x as much as patients with one chronic condition

<table>
<thead>
<tr>
<th>Nine Highest-Cost Chronic Conditions</th>
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<tbody>
<tr>
<td>Arthritis</td>
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<tr>
<td>Cancer</td>
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<tr>
<td>Chronic pain</td>
</tr>
<tr>
<td>Dementia</td>
</tr>
<tr>
<td>Depression</td>
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<tr>
<td>Diabetes</td>
</tr>
<tr>
<td>Schizophrenia</td>
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<tr>
<td>Post traumatic disabling conditions</td>
</tr>
<tr>
<td>Vision and hearing loss</td>
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</table>
Co-Morbid Chronic Physical & Behavioral Health Disorders Increase Annual Medicaid Costs by 75%

<table>
<thead>
<tr>
<th>Condition</th>
<th>No Behavioral Health Disorder</th>
<th>With Mental Illness And/Or Addiction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma or COPD</td>
<td>$8,000</td>
<td>$24,598</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>$9,488</td>
<td>$24,927</td>
</tr>
<tr>
<td>Coronary Heart Disease</td>
<td>$8,788</td>
<td>$24,443</td>
</tr>
<tr>
<td>Diabetes</td>
<td>$9,498</td>
<td>$36,730</td>
</tr>
<tr>
<td>Hypertension</td>
<td>$15,691</td>
<td>$35,840</td>
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</table>
Problem With Current “System of Care” For Consumers With Chronic Conditions

> Poor follow-up from ER visits and hospitalizations

> Multiple specialists (and multiple prescriptions)
  - Consumers with 5 or more chronic conditions see 16 physicians a year with 37 office visits
  - Fill 50 prescriptions per year
The Readmission Problem... 

> Nearly 20% of Medicare hospitalizations are followed by readmission within 30 days
  - 90% of these rehospitalizations within 30 days appear to be unplanned, the result of clinical deterioration
  - Only half of the patients rehospitalized within 30 days had a physician visit before readmission

> Among <65 Medicaid patients, 10% were readmitted within 30 days after discharge
  - 1.6X more likely than patients in private health plans

Readmissions add $15 billion in annual Medicaid and Medicare payments
“Integration” A Moving Target For Payers – Focus Is Coordination Of Care For High-Cost Consumers

Integration of Primary Care & Behavioral Health
Coordination of services to manage and address multiple chronic disease states within or parallel to primary care

Integration of Primary Care & Chronic Disease Management
Coordination of behavioral health services and primary care services to improve consumer services and outcomes

Coordination more important than integration
New Market Model – Segmentation Of Market Into The 5% & The 95%

> For the 95%, decrease of management infrastructure with competition based on consumer preference

> For the 5%, intensive care management model with focus on ‘performance’ defined as health outcomes and cost of care
For The 95%: Spend Less Via Consumer Engagement

- Management via ACOs, medical homes, and primary care
- Specialist role is secondary
- Focus on prevention and wellness
- Consumer self-care and consumer convenience is key
- Web presence (optimization, reputation, etc.) critical to get consumer referrals
- Health information exchange a requirement
For the 5%: Spend Less By Investing More

> Coordination of medical, behavioral, and social service needs by specialty group within larger system
  - Health homes
  - Waiver-based HCB programs
  - PACE programs
  - Specialty care management programs

> Assumption of performance risk (with or without financial risk)

- Cross-specialty and cross-system care coordination capability
- EHR system with real-time care management metrics
- Performance-based contracting and risk-based contracting capabilities
Change in Payer & Consumer Preference Complicated By Three Market Factors

Changes in Budgets & Financing Models

Synergistic Environmental Factors In Current Market

Emerging Developments in Neuroscience

New Functionality in Informatics & Telecommunications
Payer Financing Models & Cost Containment Programs Evolving

- Reduced fees to provider organizations
- Reduced eligibility for services at state level
- Reduce coverage of services at state level
- Risk-based, pay-for-performance, and value-based purchasing initiatives (including more managed care)
- Privatization and outsourcing

Financial pressure is speeding the adoption of disruptive innovations...
Scientific Discoveries Fueling Commercial Neuroscience Offerings

- Ability to monitor brain functionality and changes
- Discovery of possibility of brain cell regeneration
- Changing theory of brain development and maturity – longer and later
- Better understanding of brain chemistry
- Identification of genetic and epigenetic factors in behavioral and cognitive disability
Current Commercial Developments in Neuroscience

> **Innovative drug delivery systems** – patches, injectables, and genetically-designed drugs – for mental illness, addictions, dementias, intellectual disabilities

> **Better diagnostics** – brain scans, biomarkers, and more – for mental, addictive, and cognitive disorders

> **Virtual reality** and alternative reality treatment applications

> **Neurotech treatments** – stimulation-based and exercise-based
Bioconnectivity Platform
For Health Informatics

EMRs & EMR Data
(NHIN of the future)

Clinical Data
From New
Diagnostics
& Neurotech

Bioconnectivity
Single Real-Time
Clinical, Admin, &
Cost Data Set

Clinical Metrics
From Telehealth

Connection of & Access To All Data Sets Via
Web Tools – For Consumers, Professionals,
Health Systems
Telehealth Technologies

Telehealth

- Telecare & Assistive Technology
  - Smart home Technology
  - Tech-assisted cognitive retraining
  - Companion robots
- Remote monitoring systems
  - Remote vital sign sensors
  - Wearable wireless devices

- eHealth
  - mHealth
    - Smartphone applications
    - Text message alerts
  - Companion robots
  - Remote audio/video therapy
  - Real-time consultation

Telemedicine

Real-time consultation

- Remote audio/video therapy

Smartphone applications

Text message alerts

Wearable wireless devices

Remote vital sign sensors

Remote monitoring systems

Smart home Technology

Telecare & Assistive Technology

42ND NATIONAL COUNCIL mental health and addictions CONFERENCE apr 15-17, 2012 i chicago
A Look At the Future? Recent Updates to California “Telemedicine” Legislation

> “Telemedicine” now “telehealth” and includes:
  - “Asynchronous store and forward”
    - The transmission of a patient’s medical information from an originating site to the health care provider at a distant site without the presence of the patient.
  - “Synchronous interaction”
    - A real-time interaction between a patient and a health care provider located at a distant site.

> Remove requirements to document barrier to an in-person visit prior to using telehealth

> Eliminate restrictions on the type of settings where telehealth may be used

> Eliminate restrictions on reimbursement for email or telephone consultations
New Technologies Allow Innovation In Care Coordination

- Interoperable electronic recordkeeping systems
- Participation in health information exchange programs
- Smartphone and other technologies for consumer-directed disease management
- Telehealth and virtual consultation
  - Relaxation of regulatory restrictions will speed telehealth adoption

Key Market Effects Of Telehealth Adoption

- Consumer preference in retail market
- Lower cost monitoring in chronic care market
- Lower per-visit cost (e.g. $45 NowClinic rate)
- Increased productivity yield on staff time in organizations using telehealth
- Geography no longer market boundary
Disruption To The Current System – For Most Organizations Only Leverage of Technology Will Enable Success

Complexity of diagnosis and treatment

Performance that consumers want or need

Disruptive innovation brings crisis to established institutions that cannot adopt their business model

Disruption of professionals ‘less skilled’ professionals and consumers provide more

Disruption of institutions service delivery in less intensive settings

Hospital and intensive residential services
Outpatient clinics and focused-care centers
In-home care
Consumer self-care

Time
The Implications...

> Payers are moving beyond traditional FFS-based managed care for entire populations – to value-based purchasing for high-cost, complex populations

> Technologies exist – neuroscience, data management, communications – that can make great improvements in quality of service and cost reduction

> Preference will go to the organizations that can adopt to the new payer priorities
Three Elements Characterize Emerging System Designs

1. Financing Model, Rate Structure, & Rates
2. Performance Measurement & Pay-For-Performance
3. Service Delivery System
II. The Move To Performance Measurement – With Transparency
Growing Public Transparency In Performance Measurement

> Increased interest in transparency of performance of health care systems, provider organizations and professionals
  
  • Increase ‘value’ for payers
  • Facilitate consumer-directed care
Organizations With Performance Measurement Initiatives With Future Impact

1. CMS Quality Initiatives
2. National Committee for Quality Assurance (NCQA)
3. National Quality Forum (NQF)
4. Substance Abuse and Mental Health Services Administration (SAMHSA)
5. The Joint Commission
6. Center For Excellence in Assisted Living
1. Centers For Medicare & Medicaid Services

The Centers for Medicare & Medicaid Services (CMS) is a branch of the U.S. Department of Health and Human Services that administers Medicare, Medicaid, and the Children's Health Insurance Program.

<table>
<thead>
<tr>
<th>CMS Program</th>
<th>Enrollment</th>
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<tbody>
<tr>
<td>Medicare</td>
<td>47,672,971 (15% of population)</td>
</tr>
<tr>
<td>Medicaid</td>
<td>50,314,600 (20% of population)</td>
</tr>
<tr>
<td>CHIP</td>
<td>7,705,723 (3% of population)</td>
</tr>
</tbody>
</table>
Current CMS Quality Initiatives

- Medicare Quality Care Finder
- Star Quality Rating System
- Physician Quality Reporting System
Launched in August 2011

Find & Compare...

Doctors, Hospitals, Plans and Suppliers

- Get contact information for hospitals, doctors, nursing homes, home health agencies, dialysis facilities, and drug and health plans.

- Compare information about the quality of care and services these providers and plans offer.

- Get helpful tips on what to look for when comparing and choosing a provider or plan.

Select a compare tool from the left to get started
Measures in Medicare Quality Care Finder: Hospital Compare

1. Process of care measures
2. Outcome of care measures
   - Hospital readmission rate compared to national average
   - Hospital mortality rate compared to national average
3. Use of medical imaging
4. Patients' hospital experiences
   - Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
5. Patient safety measures
   - Serious complications and deaths
   - Hospital acquired conditions
6. Medicare payment and volume
Medicare Quality Care Finder – Comparing Three Hospitals in Louisiana

Bars below tell the percent of patients at each hospital who reported that YES, they were given information about what to do during their recovery at home.

**Were patients given information about what to do during their recovery at home?**

- Average for all Reporting Hospitals in The United States: 82%
- Average for all Reporting Hospitals in Louisiana: 82%
- BATON ROUGE GENERAL MEDICAL CENTER: 76%
- EARL K LONG MEDICAL CENTER: 80%
- WOMANS HOSPITAL: 87%
Survey of Patients about Their Hospital Experiences Graphs

Graph 1 of 10

How often did nurses communicate well with patients?

These results are from patients who had overnight hospital stays from January 2010 through December 2010.

Patients reported how often their nurses communicated well with them during their hospital stay. “Communicated well” means nurses explained things clearly, listened carefully to the patient, and treated the patient with courtesy and respect.

Bars below tell the percent of patients who reported that their nurses “always” communicated well.

How often did nurses communicate well with patients?

- Average for all Reporting Hospitals in The United States: 76%
- Average for all Reporting Hospitals in Pennsylvania: 76%
- HAHNEMANN UNIVERSITY HOSPITAL: 79%
- PENNSYLVANIA HOSP OF THE UP-PA HEALTH SYS: 71%
- THOMAS JEFFERSON UNIVERSITY HOSPITAL: 77%
These results are from patients who had overnight hospital stays from January 2010 through December 2010.

If patients were given medicine that they had not taken before, the survey asked how often staff explained about the medicine. “Explained” means that hospital staff told what the medicine was for and what side effects it might have before they gave it to the patient.

Bars below tell the percent of patients who reported that staff “always” explained about medicines before giving it to them.

How often did staff explain about medicines before giving them to patients?

- **Average for all Reporting Hospitals in The United States**: 61%
- **Average for all Reporting Hospitals in Pennsylvania**: 59%
- **Hahnemann University Hospital**: 69%
- **Thomas Jefferson University Hospital**: 61%
- **Virtua Memorial Hospital of Burlington County**: 60%
<table>
<thead>
<tr>
<th>Your Selected Nursing Homes</th>
<th>ANGEL &amp; JANE PAVILION</th>
<th>BETHANY VILLAGE RETIREMENT CENTER</th>
<th>CHESTNUT HILL LODGE HEALTH AND REHAB CTR</th>
</tr>
</thead>
<tbody>
<tr>
<td>8410 ROOSEVELT BLVD</td>
<td>5225 WILSON JANE</td>
<td>6833 STEINERT AVENUE</td>
<td></td>
</tr>
<tr>
<td>PHILADELPHIA, PA 19152</td>
<td>MEADOWBROOK, PA 17055</td>
<td>WYNDEMOOR, PA 19063</td>
<td></td>
</tr>
<tr>
<td>(215) 736-1200</td>
<td>(717) 764-0229</td>
<td>(215) 896-2100</td>
<td></td>
</tr>
<tr>
<td>Mapping &amp; Directions</td>
<td>Mapping &amp; Directions</td>
<td>Mapping &amp; Directions</td>
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**Overall Rating**

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<tr>
<th>ANGEL &amp; JANE PAVILION</th>
<th>BETHANY VILLAGE RETIREMENT CENTER</th>
<th>CHESTNUT HILL LODGE HEALTH AND REHAB CTR</th>
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</thead>
<tbody>
<tr>
<td>★★★★★★ 5 out of 5 stars</td>
<td>★★★ 3 out of 5 stars</td>
<td>★ 1 out of 5 stars</td>
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**Health Inspections**

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<th>ANGEL &amp; JANE PAVILION</th>
<th>BETHANY VILLAGE RETIREMENT CENTER</th>
<th>CHESTNUT HILL LODGE HEALTH AND REHAB CTR</th>
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<tbody>
<tr>
<td>★★★★★★ 5 out of 5 stars</td>
<td>★★★ 2 out of 5 stars</td>
<td>★ 1 out of 5 stars</td>
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**Nursing Home Staffing**

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<tr>
<th>ANGEL &amp; JANE PAVILION</th>
<th>BETHANY VILLAGE RETIREMENT CENTER</th>
<th>CHESTNUT HILL LODGE HEALTH AND REHAB CTR</th>
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<tbody>
<tr>
<td>★★★★★ 4 out of 5 stars</td>
<td>★★★★★ 3 out of 5 stars</td>
<td>★★★★ 3 out of 5 stars</td>
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**Quality Measures**

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<th>ANGEL &amp; JANE PAVILION</th>
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<th>CHESTNUT HILL LODGE HEALTH AND REHAB CTR</th>
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<tbody>
<tr>
<td>★★★★★★ 4 out of 5 stars</td>
<td>★★★★★★★ 5 out of 5 stars</td>
<td>★★★★★★★ 3 out of 5 stars</td>
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**Fire Safety Inspections**

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<tr>
<th>ANGEL &amp; JANE PAVILION</th>
<th>BETHANY VILLAGE RETIREMENT CENTER</th>
<th>CHESTNUT HILL LODGE HEALTH AND REHAB CTR</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 Fire Safety Deficiencies</td>
<td>7 Fire Safety Deficiencies</td>
<td>9 Fire Safety Deficiencies</td>
</tr>
</tbody>
</table>

**Penalties and Denials of Payment Against the Nursing Home**

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<tr>
<th>ANGEL &amp; JANE PAVILION</th>
<th>BETHANY VILLAGE RETIREMENT CENTER</th>
<th>CHESTNUT HILL LODGE HEALTH AND REHAB CTR</th>
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<tbody>
<tr>
<td>0 Civil Money Penalties</td>
<td>1 Civil Money Penalties</td>
<td>0 Civil Money Penalties</td>
</tr>
<tr>
<td>0 Payment Denials</td>
<td>0 Payment Denials</td>
<td>0 Payment Denials</td>
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**Complaints and Incidents**

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<tr>
<th>ANGEL &amp; JANE PAVILION</th>
<th>BETHANY VILLAGE RETIREMENT CENTER</th>
<th>CHESTNUT HILL LODGE HEALTH AND REHAB CTR</th>
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</thead>
<tbody>
<tr>
<td>1 Complaints</td>
<td>1 Complaints</td>
<td>7 Complaints</td>
</tr>
<tr>
<td>0 Incidents</td>
<td>1 Incidents</td>
<td>0 Incidents</td>
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**Nursing Home Characteristics**

<table>
<thead>
<tr>
<th>Program Participation</th>
<th>Medicare</th>
<th>Medicare and Medicaid</th>
<th>Medicare and Medicaid</th>
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</thead>
<tbody>
<tr>
<td>Number of Certified Beds</td>
<td>49 Certified Beds</td>
<td>69 Certified Beds</td>
<td>200 Certified Beds</td>
</tr>
<tr>
<td>Type of Ownership</td>
<td>For profit - Partnership</td>
<td>Non profit - Corporation</td>
<td>For profit - Corporation</td>
</tr>
<tr>
<td>Continuing Care Retirement Community</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Resident &amp; Family Councils</td>
<td>Resident &amp; Family Councils</td>
<td>Resident &amp; Family Councils</td>
<td>Resident Council Only</td>
</tr>
<tr>
<td>Located in a Hospital</td>
<td>No</td>
<td>No</td>
<td>No</td>
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</tbody>
</table>
This information comes from the Home Health Outcome and Assessment Information Set (OASIS) C during the time period July 2010 – June 2011.

How often the home health team taught patients (or their family caregivers) about their drugs.
The Medicare Star Quality Rating System was enacted with federal health care reform to improve the quality of care provided by private Medicare plans.

The system compares how well Medicare Advantage plans perform based on 50 quality measures assessed across five categories:

- Staying healthy
- Managing chronic conditions
- Customer services
- Pharmacy services
- Member satisfaction
Examples Of Measures In Medicare Star Quality Rating System

Performance measures that are derived from plan and beneficiary information collected in administrative data and data from three surveys:

> Healthcare Effectiveness Data and Information Set (HEDIS)
> Consumer Assessment of Healthcare Providers and Systems (CAHPS)
> Health Outcomes Survey (HOS) – and administrative data
### Geisinger Gold Classic 3 $0 Deductible Rx (HMO) (H3954-100-0)

**Organization:** Geisinger Gold

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</thead>
<tbody>
<tr>
<td><strong>Retail</strong></td>
<td></td>
<td>Annual Drug Deductible: $0</td>
<td>Doctor Choice: Plan Doctors Only</td>
<td>All Your Drugs on Formulary: N/A</td>
<td>$2,100</td>
<td>4.5 out of 5 stars</td>
</tr>
<tr>
<td>Annual: $166.80</td>
<td></td>
<td>Health Plan Deductible: $1,300</td>
<td>Out of Pocket Spending Limit: $1,500 In-Network</td>
<td>Drug Restrictions: N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rest of 2012: $139.00*</td>
<td></td>
<td>Drug Copay/Coinsurance: $1.10 - $3.30</td>
<td>No Gap Coverage</td>
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### Freedom Blue PPO HD Rx (PPO) (H3916-025-0)

**Organization:** Highmark Inc.

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<tbody>
<tr>
<td><strong>Retail</strong></td>
<td></td>
<td>Annual Drug Deductible: $0</td>
<td>Doctor Choice: Any Doctor</td>
<td>All Your Drugs on Formulary: N/A</td>
<td>$2,200</td>
<td>3.5 out of 5 stars</td>
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<tr>
<td>Annual: $0.00</td>
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<td>Out of Pocket Spending Limit: $2,700 In-Network</td>
<td>Drug Restrictions: N/A</td>
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<td>Rest of 2012: $0.00*</td>
<td></td>
<td>Drug Copay/Coinsurance: $1.10 - $3.30</td>
<td>No Gap Coverage</td>
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### Advanta Elite (PPO) (H5522-008-0)

**Organization:** HealthAmerica

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<tbody>
<tr>
<td><strong>Retail</strong></td>
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<td>Annual Drug Deductible: $0</td>
<td>Doctor Choice: Any Doctor</td>
<td>All Your Drugs on Formulary: N/A</td>
<td>$2,450</td>
<td>3.5 out of 5 stars</td>
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<tr>
<td>Annual: $0.00</td>
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<td>Health Plan Deductible: $1,500 In-Network</td>
<td>Out of Pocket Spending Limit: $6,400 In-Network</td>
<td>Drug Restrictions: N/A</td>
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<tr>
<td>Rest of 2012: $0.00*</td>
<td></td>
<td>$1,500 Out-of-Network</td>
<td>$10,000 In and Out-of-Network</td>
<td>No Gap Coverage</td>
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<td></td>
<td>Drug Copay/Coinsurance: $1.10 - $3.30</td>
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Physician Quality Reporting System

PQRS is a Congressionally created mandate for physicians to provide quality data to CMS.
The program is voluntary – but provides incentive payments to eligible physicians (EPs) and other professionals who satisfactorily report data on quality measures for covered services.

CMS provides a 1% incentive payment in 2011 and 0.5 percent incentive payments in 2012 – 2014 for successfully reporting PQRS measures.

Penalties will begin in 2015 for those who do not satisfactorily submit quality data.

CMS proposes to include 198 measures individual EPs can report in 2011:
- Claims-based reporting measures
- Registry-based reporting measures
- New individual measures
- EHR-based reporting measures
Examples Of Measures In Physician Reporting System: Major Depressive Disorder (MDD)

> **Antidepressant Medication During Acute Phase for Patients with MDD** – Percentage of patients aged 18 years and older diagnosed with new episode of MDD and documented as treated with antidepressant medication during the entire 84-day (12-week) acute treatment phase.

> **Diagnostic Evaluation** – Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of MDD who met the DSM-IV criteria during the visit in which the new diagnosis or recurrent episode was identified during the measurement period.

> **Suicide Risk Assessment** – Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of MDD who had a suicide risk assessment completed at each visit during the measurement period.
Examples Of Measures In Physician Reporting System: Substance Use Disorders

> Counseling Regarding Psychosocial and Pharmacologic Treatment Options for Alcohol Dependence – Percentage of patients aged 18 years and older with a diagnosis of current alcohol dependence who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12-month reporting period

> Screening for Depression Among Patients with Substance Abuse or Dependence – Percentage of patients aged 18 years and older with a diagnosis of current substance abuse or dependence who were screened for depression within the 12-month reporting period
2. National Committee for Quality Assurance

> The National Committee for Quality Assurance (NCQA) is a not-for-profit organization, funded by sponsorship, that is committed to improving health care quality

> NCQA has developed quality standards and performance measures for a broad range of health care entities including physicians – and has developed accreditation programs for a number of types of health care entities

> NCQA has two prominent quality initiatives
  - Healthcare Effectiveness Data and Information Set (HEDIS)
  - Health Plan Report Card
NCQA Healthcare Effectiveness Data and Information Set

> HEDIS is a tool used by more than 90 percent of America's health plans to measure performance
> Creates a standard data set when comparing performance of health plans
> 75 measures across 8 domains of care
  • Asthma medication use
  • Persistence of beta-blocker treatment after a heart attack
  • Controlling high blood pressure
  • Comprehensive diabetes care
  • Breast cancer screening
  • Antidepressant medication management
  • Childhood and adolescent immunization status
  • Childhood and adult weight/BMI assessment
NCQA Accreditation Programs

1. Health plan and new health plans
2. Managed behavioral healthcare organizations
3. Disease management programs
4. Wellness and health promotion programs
5. Accountable care organizations
6. Patient-centered medical homes (recognized practice)
HEDIS Measures Relevant To Behavioral Health

HEDIS includes four major measures related to behavioral health services in the United States:

> Follow-up after hospitalization for mental illness
> Antidepressant medication management
> Follow-up care for children prescribed attention-deficit/hyperactivity disorder medication
> Initiation and engagement of alcohol and other drug dependence treatment
Proposed New HEDIS® Measures for SMI Consumers

**Use of antipsychotic medications**

The percentage of members 25–64 years of age with a diagnosis of schizophrenia who remained on an antipsychotic medication for at least 80% of their treatment period.

An average of 65.7% of the individuals maintained continuous treatment with an antipsychotic for at least 80% of the time. The range across the states was 48.3% to 84.6%.

**Follow-up after hospitalization at seven and 30 days**

The percentage of members 25–64 years of age with a diagnosis of schizophrenia who had an outpatient visit, intensive outpatient encounter, or partial hospitalization following discharge from a hospitalization for schizophrenia.

An average of 36% of individuals received follow-up care at seven days and 69.7% received follow-up care at 30 days. The range across the states was 8.3% to 66.1% for seven days, and 25.6% to 88.5% for 30 days.

**Cardiovascular screening**

The percentage of members 25–64 years of age who were diagnosed with schizophrenia or bipolar disorder and prescribed any antipsychotic medication, and who received a cardiovascular health screening during the measurement year.

An average of 43.9% of individuals received cardiovascular health screening. The range across the states was 6.9% to 63.3%.
Proposed New HEDIS® Measures for SMI Consumers (cont)

**Diabetes monitoring**

The percentage of members 25–64 years of age who were diagnosed with schizophrenia and with diabetes, and received both an LDL-C test and an HbA1c test during the measurement year.

- An average of 57.3% of individuals received LDL-C test and an HbA1c test. The range across the states was 9.1% to 81.6%.

**Cardiovascular monitoring**

The percentage of members 25–64 years of age with a diagnosis of schizophrenia and a diagnosis of cardiovascular disease, who received a cardiovascular health monitoring test during the measurement year.

- An average of 54.5% of individuals received cardiovascular health monitoring test. The range across the states was 11.7% to 85.7%.

**Diabetes screening**

The percentage of members 25–64 years of age with a diagnosis of schizophrenia or a diagnosis of bipolar disorder, who were prescribed any antipsychotic medication and received a diabetes screening test during the measurement year.

- An average of 12.1% of individuals received diabetes screening test. The range across the states was 2.3% to 28.2%.
NCQA Health Plan Report Card

NCQA’s Health Plan Report Card compares the performance of NCQA-accredited health plans across the country based on HEDIS measures.

Categories Of Health Plan Ranking Criteria

- Access and Service
- Living with Illness
- Qualified Providers
- Staying Healthy
- Getting Better
Humana Health Benefit Plan of Louisiana: Health Plan Report Card

General Information
- Plan Type: Medicare
- Accredited Product: HMO
- Address: One Galliera Boulevard, Suite 1122, Metairie, LA 70001
- Number of members enrolled: 77,342
- Website: www.humana.com

This health plan serves members in the following state(s):
Louisiana

For specific areas covered, please contact the plan directly.

Accreditation Details
- Accreditation Type: Health Plan Accreditation
- Expiration Date: 11/05/2013
- Date of Next Review: 08/13/2013
- HEDIS measures included in results: Yes
- CAHPS measures included in results: Yes

Performance Results
- Accreditation Status: Excellent
- Accreditation Star Ratings:
  - Access and Service: ★★★★★
  - Qualified Providers: ★★★★★
  - Staying Healthy: ★★★★★
  - Getting Better: ★★★★★
  - Living with Illness: ★★★★★

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Plan Type</th>
<th>Accredited Product</th>
<th>Accreditation Type</th>
<th>Access and Service</th>
<th>Qualified Providers</th>
<th>Staying Healthy</th>
<th>Getting Better</th>
<th>Living with Illness</th>
<th>Overall Accreditation Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Life Insurance Company (Louisiana)</td>
<td>Commercial</td>
<td>PPO</td>
<td>Health Plan Accreditation</td>
<td>★★★★★</td>
<td>★★★★★</td>
<td>★★★★</td>
<td>★★★★</td>
<td>★★★★</td>
<td>commendable</td>
</tr>
<tr>
<td>United Healthcare of Louisiana, Inc.</td>
<td>Commercial</td>
<td>HMO/POS Combined</td>
<td>Health Plan Accreditation</td>
<td>★★★★★</td>
<td>★★★★★</td>
<td>★★★★</td>
<td>★★★★</td>
<td>★★★★</td>
<td>commendable</td>
</tr>
<tr>
<td>Humana Health Benefit Plan of Louisiana</td>
<td>Medicare</td>
<td>HMO</td>
<td>Health Plan Accreditation</td>
<td>★★★★★</td>
<td>★★★★★</td>
<td>★★★★</td>
<td>★★★★</td>
<td>★★★★</td>
<td>Excellent</td>
</tr>
</tbody>
</table>
3. National Quality Forum

> The National Quality Forum (NQF) is a not-for-profit membership organization created to develop and implement a national strategy for health care quality measurement and reporting.

> The NQF represents over 375 organizations:
  - Public and private purchasers
  - Health care professionals
  - Provider organizations
  - Organizations involved in health care research or quality improvement
  - Health plans
  - Accrediting bodies
NQF Measurement Domains

1. Ambulatory care
2. Behavioral health/psychiatric
3. Emergency medical services/ambulance
4. Home health
5. Hospice
6. Hospital/acute care facility
7. Imaging facility
8. Laboratory
9. Pharmacy
10. Post acute/long term care
NQF-Endorsed Standard Development Process

> NQF uses its formal consensus development process to evaluate and endorse consensus standards which includes:

  - Performance measures
  - Best practices
  - Frameworks
  - Reporting guidelines

> NQF uses this process to ensure the standards going forward are representative of the health care industry as a whole.
NQF-Endorsed Behavioral Health Performance Measures

1. Use and adherence to antipsychotics among members with schizophrenia
2. Depression remission at six months
3. Depression remission at twelve months
4. Utilization of the patient health depression questionnaire
5. Inpatient consumer survey
6. Bipolar disorder and major depression: appraisal for alcohol or chemical substance use
7. Child and adolescent major depressive disorder: diagnostic evaluation
8. Follow-up after hospitalization for mental illness
9. Major depressive disorder: diagnostic evaluation
### NQF Proposed Multiple Chronic Condition Measures

<table>
<thead>
<tr>
<th>High Priority Multiple Chronic Condition Measure Concepts</th>
<th>Corresponding High Priority Illustrative Measures</th>
</tr>
</thead>
</table>
| **Optimize function, maintain function, or prevent decline in function** | • Long-stay nursing home residents with moderate-severe pain  
• Long-stay nursing home residents with depressive symptoms  
• Change in basic mobility or function for post-acute care  
• Functional capacity and HRQL in COPD patients before and after pulmonary rehab  
• Lower back pain: pain and functional status assessment  
• SF-36 and SF-12 surveys |
| **Seamless transitions between multiple providers and sites of care** | • Care Transition Measure—CTM-3  
• Transition record with specified elements received by discharged patients |
| **Access to usual source of care** | • People unable to get or delayed getting needed medical care, dental care or prescription medications  
• Access problems due to cost  
• Children with special healthcare needs with access to medical home |
| **Shared accountability that includes patients, families, and providers** | • Children with effective care coordination and with a medical home |
## NQF Proposed Multiple Chronic Condition Measures (cont)

<table>
<thead>
<tr>
<th><strong>High Priority Multiple Chronic Condition Measure Concepts</strong></th>
<th><strong>Corresponding High Priority Illustrative Measures</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient clinical outcomes (e.g. mortality, morbidity)</td>
<td>• Health outcomes—mortality and morbidity</td>
</tr>
<tr>
<td><strong>Avoid inappropriate, non-beneficial end-of-life care</strong></td>
<td>• Hospice patients who didn’t receive care consistent with end-of-life wishes</td>
</tr>
<tr>
<td></td>
<td>• CARE mortality follow back survey of bereaved family members</td>
</tr>
<tr>
<td></td>
<td>• Inappropriate non-palliative services at end of life</td>
</tr>
<tr>
<td></td>
<td>• Preventable ED visits</td>
</tr>
<tr>
<td><strong>Transparency of cost (total cost)</strong></td>
<td>• Average annual expenditures per consumer unit for health care</td>
</tr>
<tr>
<td></td>
<td>• Consumer price indexes of medical care prices</td>
</tr>
<tr>
<td></td>
<td>• Personal health care expenditures, by source of funds</td>
</tr>
<tr>
<td><strong>Shared decision-making</strong></td>
<td>• Persons whose healthcare providers always involved them in decisions about their healthcare as much as they wanted</td>
</tr>
</tbody>
</table>
4. SAMHSA Performance Measurement

> 100 performance measures in 2012
  • SAMHSA is in the process of implementing National Outcome Measures for all its programs

> Performance measures are program-specific
  • Mental Health Block Grant
  • Substance Abuse and Prevention Treatment Block Grant
  • Prevention Grants
  • Innovation And Emerging Issues – Agency-wide Initiatives
  • Innovation And Emerging Issues – CMHS
  • National Traumatic Stress Network (NCTSI)
5. Joint Commission Accreditation Programs

Accreditation programs in key areas:

> Ambulatory health care
> Behavioral health care
> Critical access hospitals
> Home care
> Hospital
> Laboratory services
> Long term care
> Office-based surgery
Joint Commission Performance Measures For Behavioral Health

- Hours of physical restraint use
- Hours of seclusion
- Multiple antipsychotic medications at discharge – overall rate
- Multiple antipsychotic medications at discharge with appropriate justification – overall rate
- Post discharge continuing care plan – overall rate
- Post discharge continuing care plan transmitted – overall rate
6. Center for Excellence in Assisted Living (CEAL)

> Non-profit collaborative of 11 national organizations, has published recommendations for nine domains for assessing person-centered home and community-based services (HCBS) attributes and assisted living indicators

> The project was undertaken with Commonwealth Fund support and the recommendations have been submitted the Centers for Medicare and Medicaid Services (CMS), which is in the process of identifying person-centered attributes and indicators for its Medicaid HCBS programs
CEAL Performance Measurement Domains

1. Core values and philosophy reflect personhood; respect and dignity; autonomy, choice and independence; and privacy
2. Relationships and sense of community reflect and support belonging
3. Governance/ownership values, policies, and practices incorporate and operationalize person-centered principles
4. Leadership systems demonstrate understanding of person-centered principles and support staff empowerment
5. Workforce practices for staff and volunteers support person-centered principles
6. Meaningful life and engagement is supported by soliciting resident preferences and offering them relevant choices
7. Service delivery and schedules support resident preferences
8. Environment, or the facility spaces and visitor policies
9. Accountability on the part of the facility to use resident and staff feedback in quality improvement processes
From Performance Measurement to Pay-for-Performance

> P4P describes health care payment systems that offer financial rewards to organizations that achieve, improve, or exceed their performance on specified quality, cost, and other benchmarks

> Most approaches adjust payments on the basis of performance on a number of different measures

> Payments may be made at the individual, group, or institutional level
Growing Use Of Pay-for-Performance

> Over 100 P4P initiatives nationwide sponsored by health plans, employer coalitions, and public insurance programs.

> P4P initiative examples include:
  
  - Medicaid Behavioral Health Managed Care Systems
  - Bridges to Excellence
  - CMS Medicare Star Quality Rating System
  - CMS Value-Based Purchasing Initiative
Iowa Medicaid Behavioral Health System Measures

64+ measures with financial penalty or incentive:

1. Readmission rate 
   Rate of mental health inpatient readmission by children and adults and overall at 7, 30, and 90 days. Monitor to the following:
   • 7-day readmission for children and adults
   • 30-day readmission by children and adults 15% or less
   • 90-day readmission by children and adults 25% or less

2. Community Tenure 
   The average time between mental health hospitalizations shall not fall below 60 days for children and adults

3. Involuntary Hospitalization 
   The percent of involuntary admissions for mental health treatment to 24-hour inpatient settings shall not exceed 15% of all children admissions and 10% of all adult admissions.

4. Service Array 
   At least 6% of mental health service expenditures will be used in the provision of integrated services and supports, including natural supports, consumer run programs, and services delivered in the home of the enrollee.
Bridges To Excellence

> Physicians and physician organizations in Albany, Boston, Cincinnati, and Louisville

> Measure categories assessed:
  - Diabetes care measures
  - Heart/stroke care
  - Physician office care—implementing information management systems

> Bonus structure:
  - Per member per year (PMPY) bonus for meeting requirements for certification in physician recognition programs in each measure category
  - $80–$100 PMPY for diabetes patients
  - $50 average PMPY for meeting physician office criteria
Pay-for-Performance With Medicare Star Quality Rating System

> Uses Medicare Star Quality Rating System to ‘reward’ good performance in private Medicare Advantage plans

> Rewards to high-performing Medicare Advantage plans
  - Beneficiaries allowed to enroll in 5-star Medicare Advantage plans throughout the year – not wait until open enrollment period
  - Additional financial compensation
    - Plans with three stars or better, will get bonuses of 3 to 5 percent of their total Medicare payments

> Plans that consistently score less than three stars could eventually be out of the Medicare program
  - Proposed regulation released early this year by the Medicare agency
CMS Hospital Value-Based Purchasing Initiative

> CMS value-based purchasing proposed rules link hospital payment to delivery of “high quality care”
  - Measures are a subset of those CMS adopted for its existing Medicare Hospital Inpatient Quality Reporting Program

> Payments based on whether a hospital meets or exceeds proposed performance standards or shows greatest improvement from previous year – score based on clinical process measures and consumer experience measures

> Medicare will cut payments to hospitals one percent and set that money aside for a bonus pool.
  - Bonus payments of $850 million in the first year
  - Bonus pool would increase to two percent of Medicare payments in October 2016
  - Bonus amounts not yet determined
CMS Value-Based Purchasing: Proposed Measures On Clinical Process

> 70% of score: Clinical process of care measures, based on Medicare hospital inpatient quality reporting program measures

> Five categories include:

  - Acute myocardial infarction
  - Heart failure
  - Pneumonia
  - Healthcare-associated infections
  - Surgeries
CMS Value-Based Purchasing: Patient Experience Measures

> 30% of score: Patient experience, based on hospital consumer assessment

> Eight categories include:
  - Nurse communication
  - Doctor communication
  - Cleanliness and quietness of the hospital
  - Responsiveness of hospital staff
  - Pain management
  - Communications about medications
  - Discharge information
  - Overall rating
Evaluation of Value-Based Payment Demonstrations

> In a January 2012 issue brief, the Congressional Budget Office reviewed outcomes for 34 initiatives of 4 types of Medicare value-based payment demonstrations:

- Physician Group Practice
- Premier Hospital Quality Incentive
- Home Health Pay-for-Performance
- Medicare Participating Heart Bypass Center
## Value-Based Payment Demonstrations

<table>
<thead>
<tr>
<th>Demonstration</th>
<th>Participating Organization</th>
<th>Incentive Offered</th>
<th>Effects on Medicare Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pay for Performance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Group Practice</td>
<td>10 Physician group practices</td>
<td>Keep some of estimated reductions in the total Medicare spending, partly on the basis of the quality of care</td>
<td>Little or none</td>
</tr>
<tr>
<td>Premier Hospital Quality Incentive</td>
<td>278 Hospitals</td>
<td>Receive bonus for meeting quality-of-care targets</td>
<td>None</td>
</tr>
<tr>
<td>Home Health Pay-for-Performance</td>
<td>273 Home health agencies</td>
<td>Keep estimated reductions in total Medicare spending, if quality-of-care targets are met</td>
<td>Little or none in the first year a</td>
</tr>
<tr>
<td><strong>Bundled Payments</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Participating Heart Bypass Center</td>
<td>7 Hospitals and relevant physicians b</td>
<td>Bundled payments negotiated for coronary bypass surgeries</td>
<td>10% decline in spending on bypass surgery</td>
</tr>
</tbody>
</table>
The Only Model To Deliver Net Savings: Medicare Heart Bypass Center Bundled Rates

> Medicare made bundled payments to cover all inpatient hospital and physicians’ services for coronary artery bypass graft surgeries conducted at seven participating hospitals.

> Financing was bundled hospital/physician rate based on competitive bids

> Findings

  • The only value-based payment demonstration that yielded significant savings for the Medicare program.
  • The estimated savings in the Heart Bypass demonstration were in the range of 5 percent to 10 percent for five of the seven hospitals and were about 20 percent for the other two.
  • There were no apparent adverse effects on patients’ outcomes

> Analysis

  • Those differences were attributable to discounts that hospitals and physicians were willing to offer Medicare in their bundled-payment rates due to competitive bidding
Implications Of The World Of Transparent Performance Measurement

1. Payers and purchasers have more data for selecting partners and provider organization for referrals
2. Retail consumers have more information for selecting provider organizations and plans
3. Marketing differential for the 95%
4. Managing to performance a competitive differentiator
5. Flexible integrated data systems, performance measurement, and metrics-based management using performance data is key
III. The New Reimbursement & Service System Landscape
Three Elements Characterize Emerging System Designs

- Financing Model, Rate Structure, & Rates
- Performance Measurement & Pay-For-Performance
- Service Delivery System
The Traditional Reimbursement & Service Delivery Environment

- Payer maintains risk for unit cost and quantity of services used
- Consumers request services
- Provider organizations deliver services and are reimbursed based on volume
Payer maintains risk for unit cost and quantity of services used

Consumers request services

Provider organizations deliver services and are reimbursed based on volume

Risk transfer to MCO

Limited preferred provider network to reduce unit cost

Prior authorization requirements to reduce utilization
Three Financing & Reimbursement Option

- Fee-for-service
- Case rates, episode-based payments, or bundled payment rates
- Capitation (and subcapitation)
Fee-For-Service

> Provider paid an established fee for a defined service
  
  • Clearly defined package of services to be provided
  
  • Quality standards can be established for defined services

> Fee schedule an issue

> Varying degrees of ‘management’
Case Rates

> Payment of a flat amount for a defined group of procedures and services
  • Per treatment episode
  • Per time period

> Based on
  • Diagnosis
  • Assignment of a patient to a given type of treatment
  • Other patient characteristics
Episode-Based Payments

> Payment by episodes of care

> Episodes of care have two major dimensions:
  • a clinical dimension, including what services or clinical conditions comprise the episode
  • a time dimension that reflects the beginning, middle and end of an episode

> Commonly includes a number of treating professionals
Prometheus Payment Model Of Episode-Based Payments

Launched in 2006 by the Robert Wood Johnson Foundation, Prometheus Payment Models are used at four pilot locations:

- Crozer-Keystone Health System—Philadelphia, Pennsylvania
- Health Partners—Minneapolis, Minnesota
- Spectrum Health—Grand Rapids, Michigan
- Employers Coalition on Health—Rockford, Illinois

A bundled reimbursement for all health care services delivered in response to a particular health issue or for a package of treatment services that can be defined by diagnosis, time, or locale.

Prometheus packages payment around a comprehensive episode of medical care that covers all patient services related to a single illness or condition.
Bundled Payment Rates

Definition: Bundling patient costs into a single payment irrespective of the kinds and quantities of the services provided.

- This is very much an umbrella phrase that includes global payments and other forms of episodic payments.
CMS Proposed Bundled Payments Initiative

> Bundled payments ‘combine’ FFS payment – and replace FFS payment – by creating a single payment amount (the ‘bundle’) irrespective of the kinds and quantities of the services provided

> CMS recently issued applications for health systems interested in receiving bundled payments
  
  • The initiative will permit bundle payment across provider sites for multiple services given during an episode of care
Bundled Payment Models

Model 1
• An acute care hospital stay only – for all MS-Diagnosis Related Groups (DRGs); the bundle includes all inpatient hospital services

Model 2
• The acute care stay plus associated post-acute care – for targeted clinical conditions based on MS-DRGs for an inpatient hospital stay; the bundle includes inpatient and physician services, related post-acute care services, related readmissions, and other services to be defined in the application

Model 3
• Post-acute care following discharge – for targeted clinical conditions based on MS-DRGs for an inpatient hospital stay; the bundle includes post-acute care services, related readmissions, and other services to be defined in the application

Model 4
• Single prospective bundled payment for inpatient stays only – for targeted clinical conditions based on MS-DRGs for an inpatient hospital stay; the bundle includes inpatient and physician services and related readmissions
Geisinger Health System’s ProvenCare Bundled Payment Model

> Launched bundled payments in 2006
> Bundled payment for all non-emergency coronary artery bypass surgery procedures, including preoperative evaluation, all hospital and professional fees, and management of any complications (including readmissions) within 90 days of procedure
> Lowered hospital costs by 5%; reduced average length of stay by 0.5 days; reduced complications by 21%; and reduced readmissions by 44%
Capitation (& Subcapitation)

> The physician, hospital, or other health care provider or plan is paid a contracted rate for each member assigned, referred to as "per-member-per-month" (PMPM) rate

> Regardless of the number or nature of services provided

> Contractual rates are usually adjusted for age, gender, illness, and regional differences
Michigan Medicaid mental health services are financed on a PMPM basis.

Services are provided through 18 regional PIHPs, which are community mental health service programs (CMHSPs) or regional affiliations of CMHSPs.

PMPM ranged from 57 to $143 during the reporting period of October 1, 2006 through March 31, 2007. The average PMPM rate was $80.

Medicaid specialty services are provided in a variety of home- and community-based settings to individuals with developmental disabilities, mental illness, serious emotional disturbance, and substance use disorders.
New Service Delivery System Models

- Evolution of managed care models
- Accountable care organizations (ACOs)
- Medical homes
- Health homes
- Disease management programs
Managed Care Models

- Definition: Both a health care financing and a health care delivery that controls cost of services, manages the use of services, and measures the performance of health care providers.

- Under most plans for overall health care, a primary care physician coordinates all care for a patient. When specialists are needed, the primary care provider makes a referral. The plan member selects a primary care physician from a list provided by the plan.

- Specialty plans exist for behavioral health, radiology, pharmacy, etc.
Shifting Focus Of Managed Care In Medicaid

- In 2012, 24 states plan to expand their use of Medicaid managed care
- 14 states will expand service areas
- 10 states will add eligibility groups (Medically needy /blind/disabled populations, children in foster care system, pregnant women and children, childless adults)
- 6 states will add mandatory enrollment groups (Dual eligible population, SSI children, Foster children, Individuals in need of community-based support services, Individuals who are HIV+)
- 9 states will include managed long-term care (DD waiver services, Services for elderly and disabled, Home and community-based services, Behavioral health services, Nursing facility care)
Accountable Care Organizations

> No official definition for ACOs
> General construct — ACOs are entities comprised of health care provider organizations that agree to be accountable for the quality, cost and overall care of enrolled beneficiaries
> ACOs are being developed for both private and public payers
> ACOs are based on enhanced primary care model for care coordination
> Medical homes (AKA patient centered medical homes) a key component
Financing of Medicare ACOs

> Shared Savings Program begins with a spending benchmark — an estimate of what Medicare would spend on a certain population in the absence of the ACO
  - Calculation would be based on total expenditures for the ACO’s patient population in the three years prior, adjusted for relevant beneficiary characteristics, market factors and growth rates
> ACOs are to be rewarded or penalized based on its actual performance relative to the projected benchmarks
> ACOs are eligible for a capped percentage of the savings they generate—or liable for a share of the costs above expected levels
> To be accepted, Medicare ACOs:
  - Must meet all eligibility and program requirements
  - Must serve at least 5,000 Medicare FFS patients
  - Agree to participate in the program for at least 3 years
  - Will continue to receive payment under Medicare FFS rules
Financing Of Medicare Pioneer ACO Model Program

> Federal officials estimate the 32 Pioneer ACOs will manage care for about 860,000 Medicare patients and save Medicare $1.1 billion over five years

> For ACOs, five payment models:

1. A “core” option (four ACOs) is the standard model and is neither the riskiest nor the most conservative payment model
2. Option A (two ACOs) is the safest choice, offering the least financial risk (and potential gain) in the early years
3. Option B (six ACOs) offers the most risk and potential gain in the first year of any payment model
4. Alternative 1 (12 ACOs) includes no risk for losses in the first year, but quickly grows more aggressive, with capitation in the third year for Medicare part B
5. Alternative 2 (eight ACOs) looks like the standard model for the first two years, but then switches to capitation for Medicare parts A and B
Example: Aetna/Sharp ACO

> Aetna announced formation of an ACO with Sharp — a large independent practice association employing 700 physicians in San Diego — in December 2011

> Aetna will tie physician incentives to improvements in patients’ health

> Performance measure examples:
  
  • The percentage of Aetna members who receive recommended preventive care and screenings
  • Reductions in hospital readmission rates within 30 days following discharge
  • Reductions in avoidable emergency room visits resulting from expanded access to primary care physicians
  • HbA1C (blood glucose) tests each calendar year for members with diabetes
Example: Aetna/Sharp ACO – Service System Design Requirements

> Same-day appointments and 24/7 access to an integrated health care team
> Consultation with nurses and other health care professionals to allow for more focused physician visits
> Patient liaison services to assist patients and family members with questions about health services, referrals and improved navigation through the health care system
> Outreach from the health care team to ensure members are receiving recommended preventive care, including screenings, physicals, and lab tests
> Reminders, counseling and education services to foster wellness
> Personalized care management and support for those patients with chronic health conditions
Medical Homes

Definition: A health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family.

- Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
Health Homes

Definition: A population-based integrated care model targeting consumers with chronic conditions, which coordinate medical and behavioral health care, and community and social supports

- The health home model builds on the medical home model’s focus on acute care by incorporating linkages to other community and social supports, and enhancing coordination of medical and behavioral health care in order to better meet the needs of people with multiple chronic illnesses.
## Difference Between Health Homes & Medical Homes

<table>
<thead>
<tr>
<th>Category</th>
<th>Health Homes</th>
<th>Medical Homes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Populations served</strong></td>
<td>Individuals with approved chronic conditions</td>
<td>Serve all populations</td>
</tr>
<tr>
<td><strong>Staffing</strong></td>
<td>May include primary care practices, community mental health centers, federally qualified health centers, health home agencies, ACT teams, etc.</td>
<td>Are typically defined as physician-led primary care practices, but also mid-level practitioners</td>
</tr>
<tr>
<td><strong>Payers</strong></td>
<td>Currently are a Medicaid-only construct</td>
<td>In existence for multiple payers: Medicaid, commercial insurance, etc.</td>
</tr>
<tr>
<td><strong>Care focus</strong></td>
<td>Strong focus on behavioral health (including substance abuse treatment), social support, and other services (including nutrition, home health, coordinating activities, etc.)</td>
<td>Focused on the delivery of traditional medical care: referral and lab tracking, guideline adherence, electronic prescribing, provider-patient communication, etc.</td>
</tr>
<tr>
<td><strong>Technology</strong></td>
<td>Use of IT for coordination across continuum of care, including in-home solutions such as remote monitoring in patient homes</td>
<td>Use of IT for traditional care delivery</td>
</tr>
</tbody>
</table>
Disease Management Programs

> Definition: A system of coordinated health care interventions and communications for populations with long-term conditions in which patient self-care is significant.

- Provide a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant
- Support the physician or practitioner/patient relationship and plan of care
- Emphasize prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies
- Evaluate clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health
IV. The Strategic Implications Of The Move Beyond Fee-for-Service
The Challenge . . .

> Previous relationships with payer changing
  • Role of mission-based, tax-exempt organizations evolving
> More competition
> Technological substitution reducing price point on rates

“Competitive advantage” of health and human service organizations changing – along with sustainable business models
The “Big Implications”

> The blurring of the lines between payer, care manager, and service provider

> The segmentation of the market into the 5% and 95%
  - In the market for the 5%, competition based on ‘performance’ defined as health outcomes and cost of care
  - For the 95%, competition based on consumer preference

> Disruption in definition of ‘market’ and labor force:
  - Telehealth
  - Bundled rates + risk-based contracting
  - Managed care expansion

> The use of technology to increase the value equation (decreasing cost and increasing benefit) is key (but very different in each market)
Innovation Is The Basis Of Current Competition. . .

> Reassess market positioning – payer and consumer preference for ‘competitive’ offerings

> Assess how technology adoption can increase preference and/or reduce costs – increasing competitive advantage

❖ Sustainable business models rarely possible without deploying new technologies
Anticipating Market Changes & Identifying Future Competitive Advantage Is Key

- Bargaining Power of Customers
  - Payer purchasing policy
  - Financing models
  - Consumer choice and access

- Threat of New Market Entrants
  - Primary care
  - Urgent care clients
  - Home care providers

- Threat of Substitute Products
  - Neurotech, biotech, and pharma
  - On-line service providers
  - Rules-based ‘automated’ service delivery models
  - Consumer “self-service” tools

Future Competitive Advantage

What are payer plans for your consumer base in your market?
Questions & Discussion
The market intelligence to navigate.
The management expertise to succeed.

20+ years of market intelligence & management consulting
500+ years of collective team experience
40,000+ executive subscribers

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